

AGREEMENT BETWEEN THE STATE OF WEST VIRGINIA AND THE UNITED STATES DEPARTMENT OF JUSTICE: Report By Subject Matter Expert

December 2022

Integrating Systems • Improving Outcomes



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Introduction

In April 2014, the United States Department of Justice (DOJ) launched an investigation into the State of West Virginia’s system for delivering services and supports to children with serious mental health conditions. DOJ found that West Virginia has not complied with Section II of the Americans with Disabilities Act (ADA) and, as a result, many children with serious mental health conditions are needlessly removed from their homes to access treatment. In a May 14, 2019, Memorandum of Agreement (Agreement), DOJ recognized West Virginia’s commitment to providing services, programs, and activities to qualified children in the most integrated, least restrictive environment. The Agreement requires West Virginia to build upon this commitment by offering home- and community-based services (HCBS) to all qualified children and to reduce the number of children in residential mental health treatment facilities.

As part of the Agreement, the State was required to obtain a subject matter expert (SME) in the design and delivery of children’s mental health services to provide technical assistance to help the State reach compliance with the Agreement, prepare an assessment of the State’s compliance with the Agreement, and provide recommendations to facilitate compliance. Through a competitive procurement, the State contracted with The Institute for Innovation & Implementation (The Institute) at the University of Maryland School of Social Work to provide this subject matter expertise. In accordance with the Agreement, this contract requires that every six months The Institute draft and submit to both the State and DOJ a comprehensive report on West Virginia’s compliance with the Agreement, including recommendations to facilitate or sustain compliance. Previous reports were delivered in December 2019, June 2020, December 2020, and August 2021, and April 2022.

Structure of This Report

This report has two sections. Section One of the report details the SME’s assessment of compliance for West Virginia Department of Health and Human Resources (DHHR)’s work according to the schedule outlined in Table 1. Each requirement of the Agreement is scheduled for compliance review in a rolling fashion through the fall of 2023 when all Agreement requirements will be rated for compliance. Section Two of the report describes the State’s progress on the remaining provisions of the Agreement since the April 2022 report, and recommendations for the coming six months of work and beyond.

TABLE 1: SCHEDULE FOR PHASING-IN OF COMPLIANCE REVIEWS

Agreement Categories	Spring 2022	Fall 2022	Spring 2023	Fall 2023
Assessment	X	X	X	X
Wraparound	X	X	X	X
Assertive Community Treatment (ACT)	X	X	X	X
Quality Assurance & Performance Improvement System (QAPI)		X	X	X
Screening		X	X	X
Target Population		X	X	X

Children’s Mobile Crisis Response (CMCR)		X	X	X
Residential Reductions			X	X
Behavioral Support Services			X	X
Therapeutic Foster Care			X	X
Outreach & Education				X
Workforce				X
All Other Provisions				X

Table 2, below, defines the four compliance rating categories used. Additional details regarding the criteria used for each compliance rating, and the process, are detailed in Appendix D.

TABLE 2: COMPLIANCE RATINGS CATEGORIES

Category	Criteria
Substantial Compliance	Has undertaken and completed the requirements of the paragraph; no further activity needed OR Has undertaken and completed the requirements of the paragraph--met with updates continuing to occur.
Partial Compliance	Compliance has been achieved on some of the components of the assessed paragraph or section of the agreement, but significant work remains; Has developed deliverables that indicate the state is actively addressing the requirements of the paragraph; Has provided data that indicates the State is actively addressing the requirements of the paragraph; Has implemented activity and has yet to validate effectiveness; Has implemented activity but has not developed procedures to assess the effectiveness of the service or has not taken adequate measures to ensure its sustainability after the agreement terminates; AND/OR Has begun activities but not completed implementation activities.
Non-Compliance	Non-compliance indicates that most or all of the components of the assessed paragraph or section of the agreement have not been met; Has made little or no progress to meet the targets set forth in the Agreement, Implementation Plan or other plans; Has done no work to meet the date as set forth in the paragraph of the Agreement; OR Has not provided data or access to staff so that the Subject Matter Expert may properly assess compliance.
Not Rated	Not Rated indicates a paragraph or section of the agreement where the parties have agreed that the Subject Matter Expert shall not rate the State’s compliance during the assessment period.

Information reflected in this sixth SME report is derived from calls with State leadership and team leads, including calls with topical workgroup leads, and a thorough review of documents, data, spreadsheets, policies, memoranda, and other information provided by the State (detailed in Appendices A and B.)

Section One: SME Compliance Ratings and Recommendations:

Target Population

Screening

Assessment

Children's Mobile Crisis Response (CMCR)

Wraparound

Assertive Community Treatment

Quality Assurance & Performance Improvement System (QAPI)

Compliance Rating Introduction

The SME relies on written information submitted by DHHR, and data from the Quality Assurance and Performance Improvement (QAPI) System provided by the State to arrive at its assessment of compliance. Written documentation of compliance will focus on external facing documents shared with stakeholders/public, and internal facing documents provided to the SME by the State such as contracts, policies and procedures, training manuals, presentation, and written answers by the State to formal questions submitted by the SME.

As noted in the last report, deriving compliance from written document has limitations as even the best-intentioned policies neither succeed nor fail on their own merits; rather, progress is dependent upon the processes of implementation and related oversight and monitoring. Noting this limitation, the SME's compliance ratings will include an assessment as to whether the State's planned approach will likely result in compliance with the Agreement. The SME will rely on data from the QAPI, quantitative and qualitative survey findings, and the ongoing installation of the State's continuous quality improvement (CQI) plan in which the State implements changes to contracts, policies, procedures, practices, and regulations to improve outcomes and comply with the Agreement. The SME is also incorporating learnings from stakeholder engagement efforts, including the State's Resource Rundown and Kids Thrive (<https://kidsthive.wv.gov/Pages/default.aspx>) website.

It is important to recognize that attaining and sustaining compliance with the Agreement provisions is not a static activity; it will require the installation of infrastructure and human capital, ongoing attention to data collection, monitoring and oversight, changes to policy and practice based on that validated data and related analyses. Ongoing oversight and reporting on the Implementation Plan will demonstrate that the State has the capacity to constructively manage policy changes to continuously improve the availability, accessibility, timeliness, and quality of services for children, as it navigates the realities of changing State and Federal legislative, regulatory, and fiscal landscapes.

All criteria are applied specific to the report period reviewed. For example, a rating of partial compliance in one report period would not necessarily continue to be rated as partially compliant if there is no continued evidence of progress. A rating of substantial compliance in one report period would not continue to be rated as substantially compliant if achievements were not maintained and substantiated through policy, operating procedures, oversight and monitoring, and data collection and analysis, as applicable.

Readers will note that this report's compliance ratings section is substantially different from the last report in Spring 2022. As with the earlier report, the SME is reviewing both qualitative and quantitative information to understand both the *outcomes* achieved and the agencies and systems responsible for achieving them. To make the compliance readings clearer and more useful, we have provided a summary of activities by topic. This new format improves transparency and readability while reducing duplicative language and is squarely focused upon the substance of the Agreement itself: improving and sustaining outcomes for children in the target population. It is our intention to provide a clearer understanding of the actionable areas for the State; that is, to identify the areas of strength and direct appropriate attention to areas of weakness with related recommendations to ensure achieve or sustain initial or ongoing compliance.

As with the first compliance rating, the SME reviewed documentation including but not limited to provider and policy manuals; standard operating procedures; training curricula and evaluation; provider or public bulletins, or other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring tools and reports; audit or quality sampling plans and reports; outreach and education materials; plans or reports related to family and youth engagement; oversight and monitoring plans; CQI or performance improvement plans; West Virginia University evaluation reports; and data indicators and related analyses.

Target Population

Agreement Requirement 23

The Agreement defines that the target population shall include all children under the age of 21 who:

- a. Have a Serious Emotional or Behavioral Disorder or Disturbance that results in a functional impairment, and (i) who are placed in a Residential Mental Health Treatment Facility or (ii) who reasonably may be expected to be placed in a Residential Mental Health Treatment Facility in the near future; and
- b. Meet the eligibility requirements for mental health services provided or paid for by the Department of Health and Human Resources.

Activities

As DHHR continues its efforts to develop criteria to translate the population defined in provision a(ii) into operational parameters for data reporting and compliance oversight, the State and SME met on two occasions to address concerns raised by the SME regarding prior language proposed. In May 2022, DHHR proposed to the DOJ and SME the criteria in Table 3, below. This criterion removes the exclusion of children with attention deficit hyperactivity disorder (ADHD) to align with the federal definition of SED; and removes the provision that children were to be assessed to need residential within the next 30 days, which was a duplicative requirement that would be met through CAFAS scoring.

TABLE 3: OPERATIONAL DEFINITION TO DEFINE YOUTH AT-RISK OF RESIDENTIAL INTERVENTIONS FROM DATA SOURCES

Proposed Definition of Youth At-Risk of Residential Placement for quality sampling reviews only:		
Children under 21 with an SED and a CAFAS/PECFAS score greater than or equal to 90 (≥90).	OR	Children under 21 with an SED and one of the following in the past 90 days: <ul style="list-style-type: none"> • Incidence of acute psychiatric care hospital stay • Incidence of ED visit for psychiatric episode • Mobile Crisis Response incidence • In state’s custody due to CPS or YS involvement.
<p>Definition for Serious Emotional Disturbance (SED): Children with ICD-10 F Diagnosis Codes, excluding the following standalone diagnoses.</p> <ul style="list-style-type: none"> • F10 – F19, F55 (SUD) • F70 – F80 series (neurodevelopmental disorders) • G25.6, G25.7 (medication induced movement disorders) • Z55-65 (health hazards related to socioeconomic and psychosocial circumstances) • Z69-Z76 (Persons encountering health services in other circumstances) 		

As mentioned in previous reports, DHHR has verbally indicated that this analytic translation of the target population definition will only be used to pull data for reporting and would not be used to determine service eligibility or medical necessity criteria for services defined in the Agreement. Additionally, DHHR has stated that any child who accesses any DOJ Agreement service would be

included in any data set, even if that child did not meet these at-risk criteria. This distinction is important, as it is expected that some children will need to access CMCR, behavioral support services, and other Agreement services who would not meet these criteria.

In a September 2022 meeting, DHHR confirmed plans to begin data analysis using these criteria and has indicated plans to share its findings with the SME and DOJ when available. DHHR notes that its ability to fully implement these criteria is dependent upon the build out of the data store, and in the interim, plans to manually pull and report available data. Additionally, DHHR has listed other areas it is considering in its review of the appropriateness of the target population definition for analytic purposes including:

- Broadening the current 90-day lookback period to 365 days for children with an SED and no CAFAS/PECFAS score; and
- Other areas of system entry or access in addition to the current four areas which are: acute hospitals, EDs, CMCR, and BSS CPS or YS involvement.

The SME supports DHHR moving forward with quality analysis based on the current target population operational definition. It is the SME's opinion that a CAFAS/PECFAS score of 90 is a reasonable starting point for DHHR's target population as children with scores below 90 are not generally at serious risk for residential placement. In addition, the definition includes the four areas for entry into the system (acute hospital, emergency department (ED), children's mobile crisis response (CMCR), and Bureau of Social Services (BSS) Child Protective Services (CPS) or Youth Services (YS)), which are currently the known common entry points in addition to a family or youth self-selecting service. Additionally, The SME acknowledges the additional considerations that DHHR has noted for further analysis, including expanding the look back period to 365 days versus 90 days, and determining if there are other entry points to the behavioral health system. These are important considerations, and the SME looks forward to discussing DHHR's findings.

In January 2022, data presented to the DOJ and the SME regarding its analysis of possible target population criteria, DHHR noted a high number of youth with SUD-only diagnoses in claims and administrative data are seeking and receiving care in emergency departments and residential settings. The SME notes that as DHHR builds out its system-wide data store, it would then have the capacity to examine high rates of SUD-only diagnoses, especially considering national prevalence data regarding the high co-occurrence of mental health and substance use issues among youth. The SME recommends that this issue be revisited for future analysis when available.

Regarding an August 2021 recommendation for DHHR to clarify the length of time a youth's data will remain in the data set for quality oversight of the target population, DHHR has confirmed in discussion and in writing that youth will remain in the data set until their 21st birthday. The SME commends DHHR for aligning its data inclusion criteria to EPSDT age coverage; and further notes this will strengthen DHHR's ability to demonstrate compliance with the Agreement.

Regarding previous SME recommendations to track and report on the families who decline to pursue the CSED eligibility determination process, DHHR has initiated tracking and reporting families who decline CSED Waiver services and included this as an ongoing oversight measure in its Quality Improvement Plan. In addition, as noted in the CSED Waiver section, BMS has expanded CSED Waiver

eligibility to include families medically eligible but not income eligible. Given this expansion, DHHR is contacting families who previously declined or were not found eligible due to income and seeking their current interest in applying for the CSED Waiver.

Compliance Rating and Recommendations

Agreement Requirement 23 Compliance Rating: Partial Compliance

1. That DHHR continue its current path with its plans to begin analysis using the target population definition. The SME recommends DHHR produce data, synthesis, and plans for improvement based on review of the data to ensure that the target population is receiving access to services. DHHR has indicated the build out of the data store, and availability of all elements is occurring in phases. Current projections from DHHR indicate that full data will be available 2024, with interim data available later in 2023. As such, analysis and reporting on this item is not expected to be revisited until interim data is available in 2023, and full data available in 2024, and after.

The SME recommends that analysis include children that present to the systems listed in the definition (acute psychiatric care hospital stay, ED visit for psychiatric episode, CMCR incidence, in state's custody due to CPS or YS involvement) and do not have an SED diagnosis. Knowing this data will strengthen DHHR's ability to further divert children to community-based care and ensure that the definition is capturing the children as intended. For youth in CPS and YS custody without an SED diagnosis, it will be important to ensure that those youth have had a recent behavioral health screening documented in the record consistent with DHHR policy.

Screening

Agreement Requirements 31, 32, 48, and 49. The Agreement requires the State to ensure that all eligible children are screened to determine if they should be referred for mental health evaluation or services and that DHHR adopt a standardized set of mental health screening tools. Additional provisions require the screening of children entering child welfare and juvenile justice, as well as outreach and training on the use of the screening tools for physicians of children who are Medicaid-eligible.

Activities

DHHR's semi-annual report indicates that 94,013 Medicaid members aged 0-20 received HealthCheck exams. In looking at overall enrollment of children in West Virginia Medicaid in 2020, enrollment figures were 224,225 youth resulting in an approximate 42% screening rate. The SME acknowledges that EPSDT screening rates were likely influenced by the COVID-19 pandemic.¹

The SME pulled publicly available data from CMS regarding EPSDT screening rates in West Virginia for the most recently available year, 2020. This data is not specific to mental health screening; it includes other important screening such as lead, dental, and vision. As the table below indicates, DHHR's overall EPSDT screening rate was 52%.

¹ Center for Health Care Strategies. 2020, Oct. 9. *COVID-19 and the Decline of Well-Child Care: Implications for Children, Families, and States*. <https://www.chcs.org/resource/covid-19-and-the-decline-of-well-child-care-implications-for-children-families-and-states/>

TABLE 4: CMS GENERATED REPORTING OF STATE FORM CMS-416 DATA USING T-MSIS FY20

Description	Total	Age < 1	1-2	3-5	6-9	10-14	15-18	19-20
1a. Total Individuals Eligible for EPSDT	233,549	11,738	23,910	34,602	46,130	57,203	40,953	19,013
Total Eligible Children Receiving at Least One Initial or Periodic Screen								
	102,666	8,752	18,414	19,070	18,633	21,997	13,097	2,703
PARTICIPANT RATIO	52%	93%	80%	66%	48%	45%	38%	18%

DHHR is implementing mental health screening specific to each department, agency, bureau, or division – Bureau of Social Services (BSS) Child Protection Services and Youth Services Unit, Division of Corrections and Rehabilitation (DCR), Division of Probation Services (DPS), and Bureau for Medical Services (BMS) with Office of Maternal Child Family Health (OMCFH), with each using a designated standardized screening tool for its setting and population of youth, and with a standard operating procedure (SOP) that is specific to each bureau’s procedures. Additionally, BMS requires its managed care organizations (MCOs) to perform certain screening-related activities. Activities are summarized by Bureau. DHHR anticipates collaborating with the Department of Education during the next reporting cycle.

Specific to **BSS**, documents reviewed included the *DHHR Semi-Annual Report (July 2022)*, *DHHR PowerPoint (Sept. 2022)*, and *Addendum-BSS Pathway FAQ, BSS Implementation Pathway (revised Aug. 2022)*. The various documents indicate that BSS screening policies and related data collection are being rolled out as part of a county-by-county training effort specific to the new Assessment Pathway, which includes identifying children with potential mental health needs, and referring them to KEPRO for CSED Waiver consideration. This county-by-county roll-out commenced March 2022 and was completed August 2022, with rolling data collection beginning April 2022. BSS notes that attendance was carefully tracked and a plan for any staff that had not attended was developed to ensure that all BSS caseworkers were trained. Moving forward, new hires will receive the training as part of the new worker “In Home Case Management” training content. Finally, BSS has initiated ongoing technical assistance with regional staff regarding the Ongoing Assessment and FAST.

As the roll-out is occurring county by county, BSS screening data is not yet available; DHHR indicates that data will be included in future semi-annual reports as it becomes available. The July 2022 semi-annual report indicates plans to report the numbers of children in YS screened using the FAST tool, and the number of children in CPS screening used the Ongoing Assessment tool in future semi-annual reports. The semi-annual report notes the large numbers of children served by BSS including 2,608 youth in YS, with approximately 21 new youth entering YS monthly and 4,483 children served by CPS, with an average of 372 new children entering CPS monthly.

At the SME’s request, DHHR shared a copy of the CPS screening tool called the *Ongoing Assessment Tool*. As noted in the last report, DHHR had considered using its Ongoing Assessment Tool to meet the mental health screening requirements of the Agreement for CPS involved youth.

During development of this report, DHHR, DOJ and SME engaged in discussions about how best to meet the screening requirements for BSS CPS. Given that CPS requires and tracks that all children

entering BSS custody receive a well-child visit which includes the HealthCheck, parties agreed that moving forward HealthCheck screening rates would be used to demonstrate compliance for the CPS involved population of children.

Specific to DCR’s **Bureau of Juvenile Services**, the semi-annual report provided data for January-April 2022 for children that were screened with the MAYSI-2. Children in BJS custody ranged from a total of 221 youth in January to 242 youth in April with 96 children screened in January, 103 screened in February, 132 screened in March, and 115 screened in April. A summary table is below.

TABLE 5: SCREENING RATES, BJS

	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022
Total # of BJS youth	221	Not reported	Not reported	242
# of youth screened-SME calculated	96	103	132	115
# with a positive screen (identified MH need)	73	82	102	91
# negative screen (no MH need)	23	21	30	24

The SME notes that DHHR plans to add an overall screening rate calculation by bureau in its future reports. The SME also notes that BJS’s SOP document, *Detention Referrals to Children with Serious Emotional Disorder (CSED) Waiver* (Feb. 24, 2022), remains an internal document and is still pending approval (found in Document Response to the April 2022 SME Progress and Compliance Report, Sept. 16, 2022).

DHHR data regarding the numbers of youth with positive screens (an identified mental health need) and negative screens (no mental health need) are consistent across months. The semi-annual report notes that since BJS involved youth are not eligible for the CSED Waiver as they are in detention, but that the State’s Quality Committee recommended that DHHR, BJS, and the ASO develop a process for referring youth with positive screens prior to their discharge from detention; it noted that with the recent Waiver amendment approval, CSED Waiver referrals can be made up to a year in advance. The SME supports this recommendation from the Quality Committee and looks forward to receiving the revised policy for the next report. The SME also recommends that BJS discharges and referrals to the Assessment Pathway be included in future semi-annual reports. DHHR notes that the BJS has a draft policy regarding screening that it is using but that the SOP is not yet considered final as it is awaiting senior level review and sign-off.

Regarding **Division of Probation Services (DPS)** screening, mental health screening using the MAYSI-2 and referral processes were initiated in March 2022. The July 2022 semi-annual report reported data for 11 counties that implemented the screening process; collectively, they conducted a total of 79 screens. DHHR indicates it is working with DPS in the remaining counties to implement the new requirement and will share data in future reports.

TABLE 6: DPS SCREENING DATA FROM 11 COUNTIES, MARCH-APRIL 2022

	MARCH 2022	APRIL 2022
# of DPS youth receiving an intake (new youth entering DPS)	107	60
# of youth screened-SME calculated	37	42
# with a positive screen (identified MH need)	23	17
# negative screen (no MH need)	14	25

The SME notes DHHR’s transparency in acknowledging that DPS screening is not yet occurring statewide. From the limited data available, the SME notes the promising improved screening rates. Further, for those 40 youth who screened positive (possible presence of a mental health need), DHHR reported that 34 of those youth completed a CSED Waiver application and that the remaining six either wanted to consider the option to apply to the waiver or thought their current services were meeting their needs. The tracking of what happens for youth screened positive is an important metric to track and SME commends DHHR for including it; we look forward to future reports that will offer expanded data. The SME notes that DHHR plans to provide screening rates in its future semi-annual reports.

Previously, DHHR indicated that **Department of Education (DOE)** follows requirements established for HealthCheck. In a written reply to the SME (found in Document Response to the April 2022 SME Progress and Compliance, Sept. 16, 2022), DHHR indicates that Agreement 31 does not require DOE to screen for mental health. DHHR is planning a meeting to occur Fall 2022 to address data sharing and collaboration regarding screening, referral to the Assessment Pathway, and the range of mental health services available.

Specific to the **Bureau for Medical Services (BMS)**, the Bureau has several requirements specific to West Virginia’s EPSDT, or HealthCheck, including for its MCOs. No new information was submitted pertaining to BMS’s work with MCOs on improving screening for this report. The role of the MCOs is particularly relevant to DHHR’s screening rates. Previously, DHHR submitted four health plan reports but noted that only one of the four was populating the fields. BMS indicated that it was engaging with the MCOs to improve their EPSDT screening rates and reporting more broadly and improving mental health screening rates and reporting within EPSDT specifically.

Specific to the quality review conducted by the **Office of Maternal, Child, and Family Health (OMCFH)**, OMCFHs review of 2020 data was completed on 791 children in December 2021. This review demonstrated that nearly 80% of youth who received a well-child visit received a mental health screen, with rates ranging from 70% to 91% by differing age groups. The SME commends DHHR for its success. For children that present for well-child visits, DHHR is achieving high screening rates. The SME notes that West Virginia, like most states, is experiencing low participation in annual well child visits for older

children and youth (ages 10-14, 15-18, and 19-20)² which is also a priority population for redirection and timely discharge from residential care.

As noted in in the December 2021 report, of the 162 children and youth who did not receive a documented mental health screening at their EPSDT exam, nine (5.5%) were already receiving mental health services according to their EPSDT exam record. Variation in mental health screening by HealthCheck region was noted. Screening rates were lowest in region 5 (68.2%) and highest in region 8 (95.3%). It is interesting to note, region 8 also had the highest rate of form utilization. Region 5 was one of the lowest at only 10.6%. Further evaluation of regional discrepancies in performance should lead to recommendations for quality improvement across the state. The SME notes that the report concludes with the following priorities: “Results of the analysis will be disseminated to key stakeholders, including the state’s medical (primary care) providers, to increase awareness and acceptance of mental health screening. Likewise, and to serve as a catalyst for ongoing conversations aimed at improving the uptake of mental health screening, infographics detailing comparative performance by specified HealthCheck region will be disseminated to enable providers to understand their region’s performance verses other regions.”

Additionally, the SME notes that the OCMFH reviews included children aged 0-5 and 18-20 which was recommended in a prior SME report. Finally, the semi-annual report indicates that medical record reviews of 2021 data are in process at time of this report. The table below summarizes data from the OCMFH review.

TABLE 7: EPSDT SCREENING RATES FROM RECORD REVIEWS

	Screened		Not Screened		Total Records Reviewed
	Number	%	Number	%	
0-5 years old	264	70.2%	112	29.8%	376
6-8 years old	84	80.8%	20	19.2%	104
9-18 years old	271	90.3%	29	9.7%	300
19-20 years old	10	90.9%	1	9.1%	11
Total	629	79.5%	162	20.5%	791

In a prior report, the SME noted that BMS and the OCMFH are assessing the ability to add modifiers within the Medicaid Management Information System (MMIS) to indicate a positive or negative screen, and the timeline and actions steps needed. The SME notes the July 2022 semi-annual report describes the process to add modifiers as a Quality Committee recommendation for a BMS feasibility assessment.

Regarding efforts to promote enhanced referrals to the Assessment Pathway, HealthCheck was piloting additional SED specific questions, developed by the State, and informed by the CAFAS, along with a JOT form, a specific referral from for primary care providers to refer to the Assessment Pathway via OCMFH’s regular site visits to providers. DHHR shared a graphic provided to primary care clinicians intended for medical professionals describing how to make a referral via a new electronic portal for

² See <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2020-data.zip>

any youth with a behavioral health need. DHHR has streamlined the referral process for primary care with all medical professional referrals going to the CCRL

Compliance Ratings and Recommendations

Agreement Requirement 31, specific to DHHR shall adopt a standardized set of mental health screening tools for use to identifying who may be in the target population. Compliance Rating: Partial Compliance.

1. DHHR continues to make progress in implementing the infrastructure necessary to provide timely, statewide screening for all youth in BSS CPS, BSS YS, DCR (BJS), and DPS. Each of the bureaus have selected a screening tool, have commenced with using a tool, and are in various stages of finalizing SOPs, training staff, and tracking that staff are following the SOPs. The SME recommends that DHHR continue these current paths.
2. The SME notes that during development of this report, parties agreed that the HealthCheck screening tool would be used moving forward to demonstrate screening rate compliance for CPS involved children and youth. Given this recent decision, the SME recommends that DHHR issue revisions to its documents including SOPs, training materials, and its KPIs and Quality Oversight Plan to reflect these changes.

Agreement Requirements related to timeliness, statewide access, and that all eligible children are screened (Requirements 24,26, 28, 31). Compliance Rating: Partial Compliance.

1. Given screening is implemented across multiple agencies, separate policies and procedures have been developed specific to each agency, many finalized, some still in draft and under review to be finalized. These policies focus on mental health screening of youth at time of their entry into those various systems. DHHR has established consistent metrics that will be collected across those agencies to include the percent screened based on a count of new children, the numbers actually screened, whether those screens resulted in the identification of a potential mental health need or not, and for those with a positive screen, whether they were referred to services. Each bureau is in a different stage with its implementation, training, data collection, reporting, and oversight.
2. Given its cross-agency, statewide infrastructure is not yet in place, overall mental health screening rates remain low. In addition to its ongoing quality checks to ensure the policies are followed, it is recommended that DHHR implement a retrospective screening process for any youth admitted to a state agency that was not screened at the time of admission or entry in order to catch-up on any missing screenings. Similarly, DHHR must implement an oversight process to ensure that all youth entering a state agency are screened upon entry. Finally, DCR must implement quality improvement activities and reporting to improve screening rates.
3. The SME recommends that DHHR submit information related to its data exchange and coordination efforts with DOE and Homeland Security.

4. The October 2021 SME report reflected BMS activities to work with the MCOs to improve EPSDT screening; the SME recommends that BMS submit updated information regarding its efforts with its MCOs for the next report.

Agreement Requirements 31 specific to *Conduct outreach and training on the use of screening tools to physicians who serve Medicaid eligible youth*. Compliance Rating: Partial Compliance.

1. The OMCFH has made considerable progress to work with physicians to increase screening rates. Regarding activities within the HealthCheck program, the following activities were noted in the April 2021 report, and are recommended for updates to the SME in future reports.
 - a. HealthCheck Program Specialists were meeting with primary care providers about their own provider-specific data; sharing primary care blinded comparison data; and developing heat maps, new SOPs, and information packets about EPSDT and referral sources.
 - b. Regarding quality improvement, OMCFH was developing a broader quality improvement plan would be developed in consultation with primary care providers, stakeholders, and the Pediatric Medical Advisory Board (PMAB), a 28-member workgroup that advises OMCFH on HealthCheck matters.
2. As noted above, given the responsibilities of the MCOs include increasing screening rates, the SME requests that BMS submit information prior to the next SME report regarding its efforts with the MCOs to improve screening rates.

Agreement Requirement 31 specific to a Benchmark of 52% of Medicaid eligible children who are not in youth services, child welfare, or juvenile justice will be screened with the mental health screening tool annually. Compliance Rating: Not Met.

1. Using data in DHHR's semi-annual report, it would appear DHHR has not met its benchmark of 52% at time of this report. Given DHHR had met this benchmark previously, DHHR was going to review its data to ensure its accuracy. When pulling publicly available CMS Form 416 data for the most recently available year (2020) overall EPSDT screening rates, which include screening for more than just mental health, met the 52% benchmark. As such, the SME recommends that DHHR, DOJ, and the SME review this requirement, discuss what DHHR learned after it completes its internal validation of the data in its semi-annual report. Depending on the timing of this discussion, OMCFH's next HealthCheck quality review report may be available and may provide more up-to-date information on 2021 HealthCheck screening rates.
2. The State's HealthCheck requirements require mental health screening to be part of every well child visit, and OMCFH's sampling review shows high rates of youth screened among those that do receive well child visits. The SME commends DHHR for its high mental health screening rates as part of its well child visits – a notable success. As DHHR continues to improve its screening rates, the SME recommends that additional strategies be added to address the low occurrence of well child visits among older youth. Screening rates will improve as more

children, particularly older youth, receive well child visits. We note that the overall participation in EPSDT is low for older children and youth.

3. Specific to the thorough quality reviews conducted by OMCFH, as data trends are revealed (such as with the 2019 OMCFH report showing variations in regional screening rates) and a third OMCFH report is due in the next two months that will include 2021 data, the SME recommends that DHHR implement a rapid cycle improvement process to address the following priorities:
 - a. Improve the rates of children who receive well child visits to ensure more children can receive a mental health screening; and
 - b. The SME supports OMCFH's plan to disseminate findings to stakeholders to increase awareness and to help providers know how they compare with screening rates. However, given screening trends over two years, a continued focus only on education and awareness may not support DHHR reaching its benchmark. The SME recommends a Plan-Do-Check-Act (PDCA) cycle to influence the factors that could lead to sustainable improvement. The SME recognizes that trends noted in this third report should be used to inform that CQI effort.

Assessment

Agreement Requirements 24, 26, 28, 32, 35, 36, 40, and 52. For any child whose screening indicates a need for further evaluation, the Agreement requires the State to provide timely, face-to-face intake and assessment process delivered at times and locations mutually agreed upon by the provider and child and family. Further, the Agreement requires that the State used the Child and Adolescent Needs and Strengths tool (or similar tool approved by both parties) to assist the child and family team in the development of an individualized service plan. The Agreement also requires, for any child who has a Multidisciplinary Treatment Team (MDT), that DHHR provider the child's assessments to the MDT.

Activities

DHHR continues to make progress in its development of the Assessment Pathway to define access points for children and families from multiple referral sources. DHHR is phasing its roll-out of the Assessment Pathway work. As noted in previous reports, a Phase 1 soft launch began approximately one year ago, October 31, 2021 with a focus on direct referrals from youth/families, PCP referrals, and CMCR provider referrals. Implementation of Phase 2 began February 2022 and was completed in August 2022. It focused on BSS staff, with a county-level assessment. Future phases will be defined based on the initial roll-out.

Assessment Pathway data collected includes the number of referrals to BBH and the CCRL; referrals to BBH include referrals for interim services from the CCRL, CMCR teams, and the ASO for children applying directly for the CSED Waiver who are not involved with BSS; self-reported mental health diagnosis; and number of CSED Waiver applications to the ASO for children involved with BSS.

The most recent Assessment Pathway data was included in the July 2022 semi-annual report for January-March 2022. In that quarter, DHHR reports 193 children were referred with more than three-quarters of children aged 9-17 years. The semi-annual report notes that county level data was excluded

from the public report due to low counts, with 17 counties not referring any children, and other referring very few children. The report notes that referrals did increase across the three-month period from 37 in January to 98 in March. In addition, DHHR is tracking referrals source.

Timeliness data were also reported with DHHR tracking four distinct steps on the Assessment Pathway process. DHHR has developed specific timeliness' expectations for each of these four steps and reports data on meeting these timeliness expectations.

1. BBH is making initial contact with a family from receipt of referral from the CCRL, CMCR or ASO well within the target of five business days (actual: 2.8 days).
2. For children and families who have not yet applied for the CSED waiver, BBH works to assist them in completing the application. Of the data reported, the average is 6.9 weekdays from contact to submission, with slightly more than half (55%) of applications submitted in 10 days or less.
3. ASO's receipt of the CSED Waiver application, completion of the CAFS/PECFAS, and sharing results with BBH. Target is within four days, and although data was not reported DHHR indicates this data will be available in future reports.
4. BBH assignment of an interim Wraparound provider with DHHR indicating that for children referred by the ASO, it is meeting its five-business day target with an average of 72% occurring within five business days for those not already receiving Wraparound, or children referred from another source, it is meeting its five-to-nine business day expectation for 53%-67% of children.

The SME commends DHHR for establishing clear timelines for its own internal processes. These are important metrics to monitor, with considerable progress in meeting those timelines noted. The SME notes that timeliness data is missing for nearly one-third of children, making it difficult to determine how quickly all children and families are being assisted as they move through the Assessment Pathway. DHHR has identified data completeness as a priority in the coming months; the SME expects future reports will offer a more complete snapshot.

The SME notes that the semi-annual reports on the total period from referral to assignment of a [interim] Wraparound facilitator by BBH as occurring within 30 days for 65% of children. Linking this data to CSED Waiver data that shows access to a first face-to-face appointment for the ongoing CSED Wraparound Provider averages 58 days; as such, the SME recommends that a broader metric be included in future reporting that records access from the perspective of family and youth. When the SME adds the average timelines of these steps together and includes the period between assignment and a first face-to-face meeting with a provider (10 days to submit the CSED application, the average time to eligibility determination (34 days), and the average time to first CSED Wraparound Facilitation (58 days)), the sum shows the average family is waiting 102 days for CSED services.

The SME recognizes that BBH is assigning an interim Wraparound provider during this time to support families; the bureau strives to maintain that interim provider as the ongoing CSED Waiver provider. It will be important for DHHR to be able to provide clarity in future reports regarding interim services. For example, if families are not seen face-to-face, what types of telephonic or after-hours crisis support

are being provided. As stated in the Wraparound section, clarity on the interim service itself, and the frequency, duration, and amount, is an important metric for DHHR to include in future semi-annual report. The SME recommends that a quality review occur to reconcile these important data metrics to provide clarity on when face-to-face services occur for youth and their families.

The July 2022 semi-annual report also includes children moving through the Assessment Pathway. A total of 117 children (60.6%) of children had their application approved, 56 children (29%) either failed to respond or declined further participation, 13 children were found ineligible, four children had applications closed, and one child had a pending application. BMS sought and received approval from CMS to expand CSED Waiver services to more beneficiaries. As of July 1, 2022, income requirements for CSED waiver changed, and BBH began a retrospective review in April to identify families previously ineligible due to income and contacted them to determine interest. The semi-annual report also notes that of 117 children approved, 12 children were not yet assigned a Wraparound Facilitator, with plans to review this data.

The State also produced the August 2022 Quality Committee Review which reviewed the January – June 2022 Assessment Pathway data. That report lists the source of the initial referral by the organization submitting the referral. In this data, a significant number of families are failing to respond to final contact or declined further participation (26.4%).

BBH produced a *Pathway to Children’s Mental Health Services Phase 1 Reference Guide* in August 2022. The *Reference Guide* includes expectations for referrals from several sources, including children or families calling the CCRL. The Reference Guide lists several questions the CCRL staff will ask, including whether the child has a mental health diagnosis, is at risk of or in out-of-home placement, has an individualized education program (IEP), has been suspended from school, etc.

The State and its partners Marshall University and West Virginia University are meeting at least monthly to improve the use of CANS, including assessing outcomes for youth and families. In its September 2022 *Utilizing CANS Data to Assess Outcomes and Functional Improvement in Children receiving Mental Health Services* document, the State notes planned activities from September 2022 through February 2023, including establishing routine data transfer processes, sample analysis, reviewing sample analysis, program level reviews, and the forthcoming inclusion of baseline CANS analysis in the January 2023 semi-annual report. The State completed its *West Virginia CANS Decision Support Model: Level of Care* in September 2022 and shared it with the SME.

The SME received and reviewed the State’s *Referral for a Qualified Independent Assessment Standard Operating Procedure (SOP)* (Sept. 2022). The SOP notes that it will be piloted in “Raleigh and Fayette counties for children identified through Child Protective Services and Youth Services and then implemented across the state in various stages.” The SOP includes a definition of the target population that appears incorrect. In the definition this document says a child is considered at-risk if they have a CAFAS/PECFAS score of 90 or greater with a serious emotional disturbance **AND** [emphasis added] one the following the past 90 days: acute psychiatric hospital admission, ED visit for psychiatric episode; mobile crisis response; in state custody due to CPS or YS involvement. The “AND,” above, should be an “OR.”

The SME also received an updated (Aug. 26, 2022) *Awareness and Implementation Plan for BSS Staff on the Pathway to Children’s Mental Health Services and Reducing the Reliance on Residential Services*; an undated, draft BJS Protocol for use of the MAYSI-II and referrals to the CSED Waiver Assessment Pathway document; the FAST, Ongoing Assessment, and Case Planning Implementation Plan for Cabell and Pleasants counties (as applicable to the Assessment Pathway); the *Intensity of Intervention Services Assessment* (to be used as part of the CSED waiver application when the child is at high-risk of residential placement); a copy of KEPRO’s *Qualified Independent Assessment Results & Recommendations Report* form; and *Standard Operating Procedures (SOP): Outreach to External Audiences Regarding the Pathway to Children’s Mental Health Services*.

Compliance Ratings and Recommendations

Regarding Agreement Requirements 24, 26, 28, 32, and 40 specific to timeliness, state wideness, delivered at times convenient to the family, and a timely face to face meeting with a provider.

Compliance Rating: Partial Compliance.

DHHR has continued to make strides in this area; it has developed a process to access care, including the multiple different access points that children would be referred. As noted in prior reports, and as data submitted for this report continues to indicate, DHHR has made considerable progress in reducing the length of navigating the assessment pathway, particularly related to steps in the process that DHHR staff are responsible for. DHHR data does indicate however that length of time between a first call for a service/to be screened, and when a family receives a first face-to-face service from a provider, is very long – averaging 102 days. For the State to continue to maintain its partial compliance, and reach full compliance, the SME recommends:

1. DHHR improve the timeliness’ between a request for services/screening to time of the first face-to-face appointment. The SME is aware that this data is affected by at least three factors: (1) some of the reported timeline could be affected by the high rates of missing data fields, as noted; (2) data that may become available in future reports regarding the timeliness, frequency and intensity of interim services; and/or (3) the likely scenario that limited provider availability is impacting providers’ ability to offer a face-to-face meeting once a youth is assigned to their agency. As conveyed in the workforce section, the SME views the timeliness to get a first appointment, and the noted low intensity of services provided once someone is in services, as reflected in the CSED Waiver section, as likely provider access and workforce-related challenges. The SME notes this same recommendation is made elsewhere in the report. In addition, the SME deems the interrelated actions needed to add new providers to improve accessibility and availability of services and workforce development strategies, including assessing and modifying existing strategies in concert with providers themselves, as the highest priority for DHHR in the coming year.
 - a. Moving forward, specifically report on time from first request of a service/screening to time of first face-to-face appointment by a provider as a single metric. Currently, data is reported on steps in the process but the SME recommends that the perspective of time to get a service be reported from the youth/family’s perspective and not as steps that different bureaus do.

2. Conduct a quality improvement cycle to determine why children and families “fall out” of the assessment pathway process to improve the timeliness of the process and completeness of data. This includes determining commonalities across families who (1) are not able to be contacted; (2) who decline further participation; and (3) who have longer than mean times from referral to assessment.
 - a. Actionable items would result by examining these issues statewide and disaggregated by county and demographics; and
 - b. Identification of actionable items could be strengthened by reducing missing data on referral source, demographic characteristics including race/ethnicity and county/region.
3. In anticipation that DHHR’s referrals will continue to increase, it is important for DHHR to increase the assessment capacity by increasing the accessibility to and availability of Independent Evaluators throughout the State. Proactive steps to address Independent Evaluator availability and accessibility will assist the State in meeting the Agreement expectations of timeliness and family choice.
 - a. In the State’s Key Performance Indicators, the number of KEPRO CAFAS/PECFAS assessors has a data source but the frequency of review and person responsible for review is listed as “to be determined.” To ensure timely assessment, statewide, the State will need to regularly review the number, location, and capacity of assessors.
4. Ensure that the content and details in all manuals and training materials are correct and consistent with the Agreement requirements. For example, ensuring that the definition of target population is correct, that the BASC assessment is included as appropriate, that family choice language is consistent and repeated throughout (not just as a single sentence).
5. As noted in the QAPI section, DHHR needs to improve the completeness of the data collected. While the State has collected data on referral source and age, racial data is missing for more than half (66%) of children youth.
 - a. Specific to the collection of racial and ethnic data, the SME notes in the DHHR semi-annual report staff indicated some discomfort in asking families for this information. This is a common training opportunity with personnel and the SME recommends use of job aides, sample questions for personnel to use, and elevating the importance of asking this information.

Regarding Agreement Requirement 35 specific to assessments being conducted using the CANS. Compliance Rating: Partial Compliance.

1. The SME looks forward to receiving information about DHHRs use of CANS related information including DHHRs planned inclusion of baseline data in the January 2023 semi-annual report. The SME understands that the State’s use of CANS data is in its nascent stages. The SME anticipates that the CANS data will facilitate DHHR demonstrating compliance with Paragraph 35 , as well as applications to other Agreement requirements noted elsewhere in this report.

Regarding Agreement Requirement 36 specific to children with a Multidisciplinary Team (MDT) will be receive screening, assessment, and service plans. Compliance Rating: Partial Compliance.

1. The State needs to provide materials or documentation to the SME related to how the MDT receives the child’s assessments. DHHR has indicated that it anticipates the capacity for information sharing as it continues building out its data store. To ensure compliance with the Agreement, the State will need to provide its plan, detail the process and procedures for information sharing, as well as their strategies to measure initial and ongoing compliance with this requirement.

Children’s Mobile Response

Agreement Requirements 13, 15, 24, 26, 28, 29, 30, 40, 41, 48, and 49: The Agreement requires the State to develop Children’s Mobile Crisis Response (CMCR) statewide for all children, regardless of eligibility, to prevent unnecessary acute care. The CMCR must operate 24/7, via a toll-free number, and must have plans to respond to crises by telephone or in-person and to report data related to timeliness of response and families’ engagement in HCBS following a crisis.

Activities

CMCR is supported by a statewide call center called the Children’s Crisis and Referral Line (CCRL) which is part of a broader West Virginia call center system focused on various public and behavioral health issues (e.g., gambling), with a dedicated line and staff specific to child and family issues. This statewide number provides triage and warm hand-offs to local CMCR service providers for youth and families calling with a self-identified behavioral health crisis, and resource and referral information for non-urgent behavioral health needs. The CCRL is part of West Virginia’s broader Help4WV call line. BBH developed the CCRL to offer a dedicated response for children and families experiencing a behavioral health crisis.

The most recent available data on CCRL are included in DHHR’s July 2022 semi-annual report. CCRL calls reported July-December 2021 show a total of 187 calls, averaged as approximately 30 calls per month. The semi-annual report indicated that at least one call was received from 38 of its 55 counties. This data predates the January 2022 roll-out of the Assessment Pathway, and CCRL’s connection of children to the Assessment Pathway, which will be reported in future data. The SME recognizes that local crisis line numbers, and calls directly to the CMCR provider, are not included in this count, and are separately reported (discussed below), and therefore, a comprehensive picture of overall calls for children and families seeking support for a behavioral health crisis in the state is not yet available.

For calls to the CCRL, the SME created the summary table below from narrative fields in DHHR’s semi-annual report. The semi-annual report included disposition specifics for a subset of the 187 calls. This subset reported on 63 youth, indicating that that 26 of the 63 were referred to the CMCR through a warm-handoff, meaning that CCRL directly connected the family to its area CMCR provider via phone, remaining on the line until the connection with CMCR occurred; that one youth was referred to crisis stabilization; and one youth was connected to 911 emergency services. This is an important best practice in quality improvement, monitoring, and oversight, and the SME commends

DHHR for tracking that this practice is occurring. The report further indicated that 35 youth had no response in this referral category and DHHR plans to work with its vendor to improve data collection. The semi-annual report did not include data on the outcome on the remaining 59 calls.

TABLE 8: SUMMARY OF DHHR SEMI-ANNUAL DATA, JULY 2022

FROM FIGURE 55, WITH OVERALL TOTAL NOTED	
CCRL Referred Caller To:	Number of Calls
CMCR	26 (Source: July 2022 semi-annual)
911	1 (Source: July 2022 semi-annual)
Crisis Stabilization	1 (Source: July 2022 semi-annual)
Not categorized	35 (Source: July 2022 semi-annual)
Total subset of youth	63 (Source: July 2022 semi-annual)
Requested Resource Information	65 (Source: SME calculation based on reported 35%)
Not reported	59 (Source: SME calculation based on overall total of 187 calls reported in the semi-annual)
Total CCRL calls	187 (Source: July 2022 semi-annual)

DHHR is reporting on timeliness of warm transfers between the CCRL and the CMCR provider. The SME notes this is an important metric to track and commends DHHR for including it in its quality oversight. DHHR reported on 28 transferred calls between July-December 2022. (Note: Counts of children transferred in Figure 56 differ slightly from the count of 26 transferred calls in Figure 55 of the July 2022 semi-annual report.)

TABLE 9: WARM TRANSFERS BETWEEN CCRL AND CMCR PROVIDER

Timeliness of Warm Transfers	Number of Calls (Source: July 2022 semi-annual)
Under 1 minute	14
Between 1-5 minutes	4
Unable to reach CMCR provider	3
Missing data field for amount of time	8
Total	28

The data that is available for 18 calls (64% of total) is very positive, showing timely connection to CMCR providers from the CCRL. The SME notes DHHR’s self-identified task to work with the CCRL vendor to improve data collection on the calls missing data fields.

The SME recommends a review of the three calls in which a warm transfer was attempted but did not occur to ensure that children are timely connected to care. The SME recommends that BBH develop policy, procedure, and process for how their vendor, FirstChoice, addresses, attempts to rectify, and reports on calls that fail to transfer. For example, do they contact a different CMCR team, escalate it to BBH after hours, report it to a specific supervisory/oversight office or individual, etc. A standardized operating procedure and related policy is needed to ensure that children and families seeking warm transfer to CMCR are promptly directed to a crisis response that supports diversion and stabilization in the event the warm transfer fails. The SME recommends that any incident of a warm transfer not occurring because a CMCR provider was not available result in same notification

to BBH, and BBH conducts an immediate review. As DHHR implements its quality plan/KPIs, it will be important for DHHR to include how it may further analyze this data to understand occurrence and identify if this is a statewide issue or specific to a provider/geographic location.

The SME notes DDHR’s semi-annual report includes monitoring of filled positions within the CCRL to ensure 24/7 capacity of the CCRL. The SME supports DHHR tracking this important metric to ensure staffing meets call demand, and to inform any changes in approach needed to meet call demand.

The most recent CMCR data is derived from DHHR’s July 2022 semi-annual report. CMCR is currently funded by BBH and by BMS through the CSED Waiver. Data are reported by funder and discussed below. DHHR plans to consolidate data in future reports to provide a statewide understanding of CMCR across all payers. CMCR services provided through the CSED Waiver are minimal: from July through December 2021, 23 unique children received 91 hours of mobile crisis services (an average of four hours per child over six-month period, or, on average, less than one hour per child per month). Given that most CMCR services occur before CSED Waiver enrollment, and that Wraparound and other services are typically contacted by the families after CSED enrollment in after-hours support is needed, low numbers of CMCR services in the CSED Waiver are expected. It will be important for DHHR to understand how this data reflects any access issues after CSED enrollment (i.e., are services working as intended.)

BBH CMCR data, reported in the semi-annual, for July-December 2021 is summarized in the table below. This data reports the number of calls the CMCR provider received for the two periods listed and shows a 26% increase in calls to CMCR providers.

TABLE 10: BBH CMCR PROVIDERS CALLS FROM UNDUPLICATED UTILIZERS, JULY-DEC. 2021

Time Period Reported	Unduplicated Children Served
July-September 2021	397
October-December 2021	502

DHHR examined the number of calls per youth for the 397 youth who called CMCR during July-September 2021. Of those, 258 (65% of 397 youth) called CMCR one time, 40 youth (10%) called two times, 12 youth (3%) called 3-4 times, and 12 youth (3 %) called five or more times. Of the 12 that called five or more times, three children had 11 calls. DHHR notes that data was not available for 75 (19% of 397 callers) youth. The number of CMCR services provided to unique utilizers is an important metric to collect and the SME commends DHHR for its inclusion.

In future reports, the SME recommends the state specify what is a CMCR call intervention, what is a CMCR face-to-face intervention, and what service provision is happening under the eight-week stabilization component. Given that CMCR services have up to eight weeks of stabilization services, it will be important to understand the numbers of youth and amount and duration of that component of CMCR, including whether any of the youth with repeated calls were provided CMCR stabilization services, or if those youth experienced challenges connecting to any aftercare services that stemmed from a CMCR intervention.

Regarding the disposition of calls received by CMCR providers, DHHR analyzed 528 calls CMCR providers received during that same July-September 2021 period. Of the 528 calls received, 375 calls

(71%) were stabilized over the phone and 153 (29%) required an in-person intervention; data was not available for three calls (1%). The SME notes this is an important metric for DHHR to collect that will provide helpful information in quality oversight and monitoring.

The number of calls to a CMCR provider resolved by telephone is surprising to the SME. The SME recognizes that this data period was affected by COVID as well as general increase in telephonic response across all behavioral health services. Additionally, the SME notes that CMCR providers are also receiving calls for resources and referrals, not just crises. Even accounting for its role as a resource and referral source, that 71% of calls were resolved by telephone still raises questions about the needs of callers and the capacity of providers to meet needs that warrant further quality review. The SME recommends a quality review of the 375 calls that were telephonically resolved. It could be that much like the CCRL, local providers are receiving resource and referral calls. It is important for DHHR to confirm that a telephonic intervention was the appropriate level of support, or if providers, due to staff shortages, are spread too thin to be able to meet the needs of callers while simultaneously delivering face-to-face response. This review should disaggregate data by frequency of call, location, age, etc. Finally, DHHR has consistently stated its intent to deliver CMCR services according to best practices: that if a family states it is a crisis and asks for face-to-face CMCR intervention then CMCR providers would be expected to deliver services in the home or community. Given the high number of calls resolved by phone it will be important to confirm that this policy was followed in practice.

Regarding CMCR response time within one hour, DHHR indicates that this data is not yet available but will be reported in the future. DHHR notes that providers have reported challenges meeting the one-hour response time required. The SME is not surprised by providers' difficulties in responding within one hour given the workforce challenges and the rural geography. The SME commends DHHR for including this important timeliness metric in its quality plan as it is an important indicator of responsiveness and ability to divert crises.

It will be important for DHHR to report on timeliness to understand where providers are able to meet the best practice standard and where challenges exist as it develops quality improvement plans to support providers, and as it looks for sustainable solutions to meet the needs of youth in its rural counties. The SME does not anticipate that forthcoming data will show a one-hour response time statewide. The SME recommends that analysis of the data not be limited to statewide or overall averages but analyzes geographic, provider, and time-of-call (i.e., weekday, weekend, holiday, late night) differences. Given the high percentage of calls handled by phone, it will also be important to confirm if face-to-face interventions are only being offered during weekdays.

DHHR's semi-annual also reported on staffing for its seven CMCR providers covering six regions in the state. As of December 2021, CMCR providers had 21 staff out of an allowable budgeted 33 staff, a 65% occupancy rate. These are low staffing figures for this service, given that it is available 24/7, 365 days a year, and each intervention may last several hours and require follow-up to ensure that the child remains stabilized and is connected to home- and community-based services and supports.

The SME notes several self-identified tasks that DHHR plans to undertake including working with the vendor to improve data collection; education efforts to increase calls to the CCRL; review of calls that are unable to be transferred in a timely manner; and increasing data collection and referrals

from schools, EDs medical departments, and rural areas. These tasks are important in improving DHHR's understanding of service referral and delivery.

While data is incomplete, and a comprehensive understanding of CMCR services is not yet available, the SME notes DHHR's considerable efforts to build infrastructure to support effective delivery of CMCR, develop a system to collect and report data, DHHR's plans to collect metrics for quality efforts and demonstration of compliance, and its CQI plan outlining its planned quality improvement processes. As noted, the SME has identified several areas for quality review. The SME recommends that DHHR initiate use of its quality oversight strategy to conduct a quality review of CMCR, identify areas that require a quality improvement approach, convey its plans, and begin to implement strategies.

To assess compliance of internal operating procedures and policies to ensure consistency with the Agreement, DHHR provided a document titled CCRL-DHHR Grant Agreement. It is the State's contract with the FirstChoice, the vendor for the CCRL. The SME notes that contract language requires 24/7 availability of qualified and trained staff, clinical supervisor availability, and requirements specific to call response, handling of crisis calls and warm transfer to the CMCR providers, and performance and outcome measures and administrative data.

DHHR also provided the SME with a copy of FirstChoice vendors policy and procedures manual (March 2022) and a *CCRL Referral Guidance* document (March 15, 2022).

The SME notes that FirstChoice is the State's call center for numerous support lines and that the FirstChoice policy manual provided by DHHR appears to be a general policy and procedures manual applicable to multiple call lines. It offers guidance to staff such as how to support a caller presenting with suicidal thoughts, or how to respond to a caller that is inappropriate with call center staff. While the manual provides useful direction to staff, it is adult focused and general in nature. The March 2022 *CCRL Referral Guidance* document, which is a separate document from the CCRL's policies and procedures manual, does contain the types of information necessary for CCRL staff to follow when a youth presents in crisis. BBH has conveyed that it was developed with FirstChoice staff and is in use by its call center. This document addresses important and necessary procedure for a CCRL call center, including what to do if a youth presents in crisis or presents with suicidality, when to consider referring to the Assessment Pathway, how CCRL conducts warm handoffs to CMCR, resources for parents and grandparents, when to refer to the Regional Youth Services Center or Comprehensive Behavioral Health Centers. The SME recommends this CCRL referral guidance document be incorporated into the CCRL's other formal documents that exists with this vendor, such as referencing it in their contract, incorporating the content into CCRL's policy manual, referencing it as a special appendix in that manual, or creating a standalone FirstChoice policy manual specific to the CCRL. The SME notes that BBH intends to update its internal policies manual by December 2022 and recommends the issues noted above be addressed in that revision.

Regarding the assessment of DHHR's compliance with required competencies and trainings for staff, the SME notes that Agreement requirement 29 stipulates that the system will include a toll-free hotline that directly connects callers to a mental health professional and that mental health

professional for the hotline must have experience or competency-based trainings in working with children and crisis. The SME recommends that DHHR provide information regarding the credentials of staff answering the phones; the required experiential, educational, and other competencies; and any training they receive specific to addressing calls from children, youth, and their families.

The SME recommends that training address the needs of children, particularly as children and youth present differently than adults; that is, youth experience self-injurious behaviors or suicidality present with different behaviors, thoughts, and emotions than adults. DHHR will need to ensure that CCRL staff are trained in de-escalation and trained to discern acting out or aggressive behaviors as separate from safety issues requiring a 911 intervention.

The *CCRL Referral Guidance* document states that the CCRL will connect youth who present with suicidality to the Suicide Intervention specialist at the Regional Youth Service Centers. The diagram identifies this as a resource, in addition to the CMCR, to ensure necessary follow-up and connection to resources for youth who present with suicidality. This is an important expertise and the SME is pleased to see that the referral guidance includes referral and data collection relevant to this resource.

The SME notes that Agreement requirement 30d-hotline staff will have access to needed info about the child and family (i.e., existing crisis plans and individual service plans) requires additional discussion between the parties to clarify intention. This item was not reviewed for this report. Discussions are planned for November 2022 and this item will be reviewed in the next SME report. BBH provided a quality monitoring plan, *Children's Crisis and Referral Line Quality Assurance SOP* (Sept. 8, 2022) describing plans to conduct secret shopper calls to ensure quality, timely response of the CCRL. The SME notes the thoroughness of the plan, including its sampling methods. The SME recommends that BBH consider for inclusion the secret shoppers' report of time elapsed between requesting crisis services and warm-handoff to the CMCR. While the metric is reported by CCRL in its data, cross walking the secret shoppers' experience with this important data point may assist the State in identifying additional quality improvement opportunities. The SME commends DHHR for engaging in such an important aspect of quality oversight; and looks forward to the future data that comes from that process.

One theme that occurs as the SME examines data across services, is that county response varies widely. As noted, the data presented in the semi-annual report shows calls originating in 38 of 55 counties. Other services also show geographic variation in referrals and access to services. As such, the SME recommends that county-specific analysis occur, across services, to begin or continue identifying and resolving geographic disparities.

Prior SME reports updated the progress that BBH and BMS have made to develop a single CMCR provider manual to be used by BBH and BMS CSED Waiver staff. The SME has received and commented on drafts beginning Fall 2021, with a revised draft in February 2022, but notes that of Fall 2022 the manual is not yet finalized.

In terms of outreach and education efforts: BBH has requested marketing plans from CMCR providers regarding efforts to inform communities about their service. The SME requests BBH provide statewide data analysis of those marketing efforts, indicate any areas for resolution, and their plans to support providers in widening and deepening their outreach. Prior reports referenced two outreach and education documents: a spreadsheet, *CCRL Outreach Inventory July-December 2021*, was shared with the SME for inclusion in this report. It tracks dates, areas of the state, events, and numbers of persons reached to inform people about the availability of the CCRL. The document lists monthly efforts July-December 2021 to inform people about the availability of the CCRL, from displays and presence of staff at in-person events to mailed information. These also reflect important efforts that should continue to be updated.

The SME also received a copy of an email, *CCRL Outreach Annual Plan FirstChoice February 2022*. The email is to the CEO of FirstChoice, and after communication with the State, the SME learned it refers to a contract spanning September 2021 through September 2022. The SME notes the email lists planned dollar investments for specific outreach methods such as billboard ads, conference exhibit fees, and social media costs. The SME recommends continued reporting of these efforts in its future semi-annual reports.

Compliance Ratings and Recommendations

Agreement Requirements 13, 15, 24, 26, 28, 29, 30, 40, 41, 48, and 49, Compliance Rating: Partial Compliance.

1. The SME recommends that DHHR continue its current efforts to collect, report, and act upon data findings. DHHR has planned to collect and use important measures that will inform timely statewide access. DHHR has a thoughtful quality monitoring plan to support improvements. As noted elsewhere throughout the report, the SME recommends implementing the rapid cycle improvement noted in its Quality Plan to priority areas that are emerging in the data.
2. Ensure the warm-handoff policy between CCRL and CMCR providers is followed by:
 - a. Implementing a prospective procedure for CCRL to provide daily notification to BBH when a warm transfer was attempted but did not occur, with immediate follow-up to the CMCR provider by BBH to assess what led to the no response, and what quality improvement processes should be initiated within what timeframe; and
 - b. Conduct a retrospective quality review of previous warm transfers that did not occur, and based on findings, implement quality improvements plan to address any statewide, systemic, or provider-specific challenges.
3. Given the volume of calls resolved with telephonic support only, and the number of repeat calls, the SME recommends that DHHR conduct a quality review to ensure that calls are receiving the appropriate level of intervention needed. For example, that the caller was seeking resource information and did not need immediate services or if the rate of telephonic intervention indicates staffing challenges.
4. Expand current policy and procedures content across DHHR, CCRL, and CMCR providers to address:

- a. BBH expectations for how the CCRL should handle a call when a warm transfer to a CMCR provider is attempted but the CMCR does not respond;
 - b. Expectations for how the CMCR provider initiates quality improvement when this requirement is not followed; and
 - c. Formally incorporate the CCCRL Referral Guidance document into existing FirstChoice vendor documents.
5. Provide the SME with the specific training requirements, credentials, and staff experiences for staff of the CCRL consistent with Agreement requirement 29. Cross-referencing to SOW and FirstChoice policies, ASIST is not included as required training. This is an important example of the training requirements that would be useful for the DHHR to clarify. The SME notes that ASIST training is not specific to the needs of children and recommends incorporating content to address the needs of children, particularly as children and youth experiencing suicidality present with different behaviors, thoughts, and emotions than adults. Additionally, many child-related calls will be youth presenting with acting out behaviors or aggression. The CCRL staff need to be trained in recognizing these behaviors, how to support de-escalation of those behaviors, and most importantly training to discern when acting out or aggression does and does not require a 911 intervention. Finally, that the recommend content be added to the existing manual or created as a standalone document specific to CCRL. Specifically, content should include listing CCRL as one of the call center lines they operate; include or incorporate more child- and youth-specific examples for recognizing suicide, self-injury, the need to call 911, and the more typical presentation of youth which is aggression and acting out; and should include CCRL de-escalation strategies rather than reverting to 911 emergency services.

Agreement Requirements 41, 48, and 49, Compliance Rating: Partial Compliance

- 1. For data reported:
 - a. In future reports, the SME recommends the State specify what service provision is happening under the eight-week stabilization component of CMCR alongside its existing reported telephonic and face-to-face service data. Current data does not include this level of specificity and as such does not provide an understanding of any ongoing CMCR service provision. Given that CMCR services have up to eight weeks of stabilization, it will be important to understand stabilization utilization, and if any of the youth with repeated calls received CMCR stabilization services, and any challenges the CMCR had in providing or connecting youth and families with stabilization services.
 - b. Continue to improve completion rate of data, including demographic data. The SME notes that during a crisis call, it is clinically appropriate to not focus on the collection of administrative data; therefore, some data will continue to be missing in any data set.
 - c. The SME recommends that BBH continue to monitor regional and county variation, and through its CQI processes, address any disparities.
 - d. In future semi-annual reports, the SME recommends that DHHR include details regarding how it is developing, implementing, and sustaining quality improvement planning.

- Specific to outreach and education, continue efforts with CCRL and CMCR providers to promote the availability of CCRL and CMCR with strategies refined based on data analysis such as regional/county variation, and for DHHR to continue to report on these efforts in its semi-annual reports.

Wraparound

Agreement Requirements: The Agreement requires the State to ensure statewide access for each child identified as needing in-home and community-based mental health services, with a child and family team (CFT) managing the care of each child. Further, the Agreement requires that each CFT operate with high fidelity to the National Wraparound Initiative’s (NWI) model and use the Child and Adolescent Needs and Strengths (CANS) assessment or other assessment tool to develop an individualized service plan (ISP). Additionally, for any child who has a multidisciplinary treatment team (MDT), the screening and assessment and ISP must be made available to the MDT.

Activities

DHHR’s July 2022 semi-annual report provides the most recent available data on Wraparound utilization. Currently Wraparound data is separated by payor (BBH or BMS CSED Waiver), with DHHR planning to aggregate data across DHHR payors in future reports per SME recommendation. As such, a consolidated statewide understanding of Wraparound enrollment, distinct children served, and the amount of service each child is receiving, is expected in future reports.

BBH-funded Wraparound served 138 children during one three-month period (July-Sept. 2021) and 117 children during the subsequent three-month period (Oct.-Dec. 2021). BBH notes that each child received on average four hours of Wraparound service a month. The enrollment timeframe for each unique youth is not reported; as such, service hours per unique youth is not available.

During an 18-month period (July 2020-Dec. 2021), the CSED Waiver Wraparound service served 220 unique youth for a total of 4,551 hours of service.

TABLE 11: WRAPAROUND SERVICES

	BBH- funded Wraparound	CSED Waiver Wraparound
July-September 2021	138	90* (September figure)
October-December 2021	117	116* (December figure)
Average hours per month	4	4

The July 2022 semi-annual report notes that review of intensity of service requires further analysis and work with providers to expand capacity to increase service intensity.

DHHR has developed a single *West Virginia Wraparound Manual* with expectations consolidated and aligned across all three bureaus, as recommended by the SME in previous reports. Dated September 12, 2022, it is a 10-page provider manual addressing goals of Wraparound, how to become a Wraparound provider, access to the CSED Waiver, assignment of interim Wraparound services during the CSED eligibility process, timeline requirements for completion of the CANS and a child and family

team within 30 days, clarification that services are voluntary, and that the plan of care should reflect the child and family's needs. The manual also addresses requirements for reporting each Wraparound facilitators capacity (number of families serving), how to access training through Marshall University, and expectations that providers participate in Marshall University fidelity reviews. The manual addresses that Wraparound services must be provided weekly; if services are provided less than weekly, it must be documented in the plan of care (POC) and approved by the CFT. Additionally, the manual includes clear language on two important policy decisions DHHR made in its effort to ensure statewide capacity: (1) that all BBH and SAH Wraparound providers become CSED providers and (2) DHHR's efforts to support continuity of care for a youth by allowing their prior established outpatient therapist to continue as their therapist by billing Medicaid as opposed to the CSED Waiver. The SME recognizes these as useful and helpful policy decisions.

The SME notes that the *West Virginia Wraparound Manual* explicitly states that Wraparound services must be provided at mutually agreed upon time and locations based on the child and family's preferences consistent with Agreement requirement 26 and that services are voluntary consistent with Agreement requirement 27. The SME notes that DHHR is still considering how to measure and monitor these Agreement provisions. The SME expects that information from fidelity reviews and quality sampling will be informative and looks forward to receiving further clarifications from DHHR on its measuring and monitoring of this issue in its next updated CQI/KPI document. DHHR's implementation plan does not yet reflect a distribution and dissemination plan for the manual..

DHHR has also developed a single POC document to identify the needs of youth and their families, detail individualized goals and action steps, and monitor the progress through the child and family team. DHHR is requiring that all providers use this standard POC beginning October 1, 2022. Marshall University has initiated training on the POC and plans monthly POC office hours. Additionally, a concurrent *Desk Guide and Instructions* document describes how to complete the POC. DHHR's POC is a comprehensive document, developed consistent with NWI standards. The companion desk guide, and related Marshall University training, included the recorded session and slide deck, are helpful tools to support providers to implement the POC and are also consistent with NWI standards. The consolidated POC is a well written plan of care, consistent with fidelity wraparound practice; and will support the State in their compliance with Agreement requirements 12, 16, 21, and aspects of 33 and 35. The SME understands that the roll-out of this new POC began October 1, 2022; we look forward to quality and practice updates in DHHR's next semi-annual reports, future fidelity reports, future quality reviews, and qualitative and quantitative reports.

DHHR has contracted with Marshall University (MU) to implement CANS and Wraparound training and coaching. In turn, Marshall University has contracted with the National Wraparound Implementation Center (NWIC) to support MU's development of a Wraparound training and coaching infrastructure in West Virginia. MU maintains a public-facing webpage for providers of MRSS and Wraparound [Home - Wraparound and Mobile Response Training Assistance \(wvbhtraining.org\)](http://wvbhtraining.org) as part of MU's broader DHHR supported WV Behavioral Health Workforce and Health Equity Training Center. [Home - WV Behavioral Health Workforce and Health Equity Training Center \(wvbhtraining.org\)](http://wvbhtraining.org) The Wraparound and MRSS-specific page provides easy to locate information to access to the listserv, documents, trainings, and announcements. Marshall University

has released three NWIC documents that support the training and coaching of Wraparound facilitators in West Virginia: (1) *NWIC Workforce Development Plan*, which is a graphic that describes the various trainings facilitators will receive; (2) a training calendar detailing dates and rotations of the trainings; and (3) and a *NWIC Wraparound Training Participant Manual* for its' three-day provider Wraparound practice training. In addition, MU Wraparound coaches, supported and trained by NWIC, have been assigned to all the West Virginia Wraparound providers, with plans to commence individual, provider-specific coaching late fall. As MU builds a state-specific infrastructure and its own expertise in Wraparound, NWIC will reduce its direct training and coaching role and MU Wraparound coaches will sustain West Virginia-specific Wraparound training and coaching.

Monitoring fidelity to NWI standards is an essential component to maintain quality Wraparound services. MU has contracted with the University of Washington's Wraparound Evaluation & Research Team (WERT) to implement Wraparound fidelity monitoring. Activities commenced in Spring 2022 with a detailed schedule for selection of records and training culminating in a first fidelity report that will be completed November 2022. The SME received MU Fidelity Training slides, work plan schedule, and written updates on its progress. Provider trainings commenced late Spring and Summer 2022 and introduced providers to the Document Assessment and Review Tool (DART) and the Wraparound Fidelity Index, Short Form (WFI-EZ) tool, the planned approach for the fidelity review, including use of CANS data, and expectations for provider participation.

MU has contracted with both the NWIC, and Washington's University's WERT in support of implementing Wraparound. Both are part of a national tri-university effort (with Portland State University, who developed the NWI standards), to measure fidelity to Wraparound and train to fidelity wraparound. The SME acknowledges MU's contracted efforts and in turn DHHR's commitment to working with the developers of the NWI standards.

Compliance Ratings and Recommendations

Agreement Requirements 16, 24-28, and 40, Compliance Rating: Partial Compliance

1. A consolidated statewide understanding of Wraparound enrollment, unique children served, and the amount of service each child is receiving, is planned to be reported in future DHHR semi-annual reports but is not yet available. At present it is difficult to draw firm conclusions about access, intensity, and timeliness of service provision with currently available data. DHHR needs to provide data that includes unique utilizers, timeliness of receipt of services, and amount and duration of services received. The SME recommends data be disaggregated by provider, age, region, and length of stay, in addition to a total or statewide aggregated reporting. Given DHHR's plan to review individual care plans as part of its quality oversight and Wraparound fidelity reviews to ensure NWI standards, which includes individuation of each plan of care for each child, this type of data would be used to support fidelity efforts to ensure that services are individualized to the youth and family. Additionally, data stratified by providers will support DHHR's quality oversight, inform an understanding of system strengths, and identify challenges that require training, support, or policy revisions.
2. It is important that DHHR provide information reported from the unique utilizer perspective as opposed to solely by-service. To fully understand the intensity and duration of services a

child receives, one must be able to view all services the child is receiving; that is, services provided under the CSED waiver, Medicaid state plan services, and BBH-funded services.

3. Based on current data, it is difficult to know if data reported by BBH is capturing interim services, ongoing services for youth who did not meet CSED eligibility, ongoing services for youth that declined CSED Waiver participation, or some combination of all three. DHHR will need to differentiate these in future data reports, as well as data on intensity, duration, and timeliness of each.
4. DHHR needs to confirm whether all BBH and SAH providers have completed the process to become Medicaid CSED waiver providers; if not, the State needs to provide the number still outstanding and the timeline to complete enrollment. In addition, the State needs to provide information as to whether those providers are actively enrolling children in Wraparound services. Requiring Medicaid enrollment was an important policy step that DHHR undertook to increase accessibility. Given that some BBH and SAH providers have indicated concerns about becoming Medicaid providers, the SME anticipates that DHHR may need to continue to work directly with providers to address any questions or concerns.
5. Based on available data, it does not appear that West Virginia has sufficient capacity to sustain the provision of services to children currently enrolled and expand services to meet projected need for Wraparound. While enrollment data indicates that more children are receiving services over time, it appears that service intensity (i.e., hours per month) remains low or has decreased. This is typically an indication that a limited provider pool is working to serve more families but is not able to provide the amount of service expected, and potentially needed, to each child and family. Two priority areas to begin to improve the issue includes:
 - a. Reporting data by unique utilizer, as noted above, so that the amount and type of services each child is receiving is known; and
 - b. Report enrollment and service intensity by provider to clarify issues of difference in provider practice across the state. At present, it is difficult to discern whether accessibility, variations in provider practice, or both are affecting service delivery.

Agreement Requirement 12, 21, 22, and 33-36, Compliance Rating: Partial Compliance

1. Maintain efforts to conduct fidelity reviews as initiated through contract with MU and collect and synthesize fidelity data at regular intervals to include statewide understanding of fidelity, and individual provider reports to support improved provider performance. The SME looks forward to receiving the State's first fidelity review report in November 2022. The SME does not expect that the review will show achievement of NWI fidelity. No state achieves fidelity initially; it takes time for states to mature and deepen their Wraparound practice. The important construct is quality improvement, working towards fidelity, addressing statewide improvements across all providers, and individual coaching to achieve provider-specific improvements. Following the November 2022 fidelity report, the SME expects that DHHR will revise its Wraparound training and coaching plan and make any needed modifications to its quality improvement plan.

2. Expand the content and details addressed in the West Virginia Wraparound manual. The existing content is a good start, addressing important information to support providers to deliver Wraparound. However, the SME notes that the manual is lean on details. The SME recommends that the West Virginia Wraparound manual be expanded in its next annual revision to provide more details regarding DHHR operational requirements and practice expectations in the delivery of Wraparound services. The SME recognizes that some of these details may live currently in other documents such as contract language but staff typically do not have access to contract language. The SME recommends that DHHR develop a more comprehensive and detailed manual that consolidates information now contained in various places to guide consistent quality practice across providers. Examples of notable Wraparound manuals include New Jersey, [Louisiana](#), [Massachusetts](#), and [Washington](#).
 - a. Additionally, the SME recommends that the manual explicitly address the following details consistent with Agreement requirements, including the role of the Wraparound facilitator, the role of the CFT Team, and expectations regarding interagency collaboration. The current WV Wraparound manual does not address important operational aspects of the service. These additions would include staffing ratios, supervisory ratios, and expectations; roles/job descriptions; integration of Wraparound with operations in West Virginia (i.e., submitting care plans to Aetna, service authorizations, coordination with other providers); process to address disagreements among the CFT team; expectations for activation of natural supports; how the providers interface with Aetna for service approvals; if CFT is determining medical need for services, or how disagreements between Aetna’s medical need determinations and the CFT are resolved; how Wraparound interfaces with other systems and providers, including child welfare caseworkers and MDTs, court systems, schools/IEP issues; how Wraparound providers support the participation of other behavioral health providers in CFTs, as well as resources or directions to expectations for how those other behavioral health providers are expected to participate in the CFT; and a description of the types of services and supports that Wraparound providers are expected to engage. The interface processes with Aetna are recommended as priorities as these are consistent challenges in other jurisdictions that DHHR could clarify to avoid any unnecessary system challenges.
3. Align DHHR policy with NWI standards. The SME notes two NWI related issues: (1) current DHHR policy is inconsistent with NWI standards regarding the allowable ratio of facilitators to youth; NWI standard requires *no more than* a 1:10 facilitator to youth ratio but DHHR allows a 1:15 ratio and (2) the manual does not address the NWI standard requiring that Wraparound facilitators be dedicated as facilitators versus having multiple roles with the families. This issue was discussed early on with DHHR when they were considering adopting this standard and changing their pre-existing policy allowing “multiple hats.” The SME notes that this is not addressed in the manual, contract, training materials, or related SOP documents. The SME recommends that staffing ratios follow NWI standards with no more than 1:10 facilitator to youth ratio. The SME requests confirmation of DHHR’s plans to follow the NWI requirement for dedicated facilitators and recommends that both issues be

specifically addressed in SOP, contracts, training materials, manuals. While recognizing the staffing challenges that DHHR is experiencing, the data on these provisions clearly demonstrates that these are core to achieving fidelity.

4. As discussed, MU is implementing NWICs training guide. This training guide includes important details for how Wraparound should be delivered. The SME recognizes that MU brought in NWIC to provide training and coaching support, and therefore NWIC materials are being used. As MU moves to sustaining training and coaching, and fidelity monitoring in future years, the types of NWI practice expectations that reside in NWIC documents will need to reside in DHHR documents, such as the West Virginia Wraparound manual.
5. Ensure that POC reviews are part of quality oversight, training and coaching efforts, quality reviews, and improvement plans.
6. Develop CQI plans, and implement measurable change processes to improve Wraparound delivery, fidelity, quality, access and intensity, and youth and family satisfaction such as improved timeliness for receipt of Wraparound facilitation. DHHR has initiated development of key infrastructure to provide Wraparound training and coaching, and fidelity monitoring to NWI standards. These structures need time to mature. DHHR needs to use its CQI processes to improve identified areas, and plan for maintaining fidelity to NWI standards through ongoing training, coaching, and fidelity monitoring.

Assertive Community Treatment

Agreement Requirements 24, 26, 27, 28,36, 39 40, 52: The Agreement requires the State to ensure that Assertive Community Treatment (ACT) is available statewide to members of the target population aged 18–20, delivered at times mutually convenient, that youth and families may decline services and services are individualized to the youth’s needs. The Agreement permits ACT teams to substitute for CFTs, provided they develop an ISP and ensure access to HCBS, as appropriate.

Activities

The State’s July 2022 semi-annual report provides the most recent data regarding ACT services. It included a count of individual youth and days per youth by month for July 2020-December 2021; an average of 3.6 young people receive ACT each month, of whom 80% are male. The State notes that it perceives low enrollment partially as a condition of “pandemic-related concerns among youth in addition to low historic participation rates among transition-age youth.” In addition, the State asserts that the presence of the CSED waiver and services accessed prior to turning 18 may suppress ACT utilization. The State anticipates additional evaluation of utilization after three to five years of CSED waiver operation.

Discharge reason information is not collected, but the DHHR report indicates that likely many youth “are transient and do not want someone intruding in their lives.” The State Quality Review Committee has recommended exploring ACT use in other states and national averages, as well as “explor[ing] data collection of discharge reason data to further understand and seek opportunities for transient youth resistant to remaining with ACT services.”

In response to the last compliance review, the State provided the SME with a revised KEPRO Assertive Community Treatment Scoring Tool dated August 28, 2022. The SME notes that KEPRO uses this tool as a retrospective review tool with items and scoring modified from the Dartmouth Assertive Community Treatment Scale fidelity instrument. The KEPRO review tool requires organizations to achieve a 70% score or greater based on a total score; organizations with retrospective review scores below 70% across a total of scored items will be required to complete a technical assistance plan and a follow-up for review will be scheduled, if necessary.

The SME recognizes the developmentally appropriate desire for autonomy among young people but simultaneously recommends the State increase awareness of ACT among youth people. (Discussed below, under Stakeholder Outreach.)

Compliance Ratings and Recommendations

Agreement Requirement 24 and 39, Compliance Rating: Partial Compliance

ACT is provided through the BMS as a Medicaid state plan service to eligible members ages 18 and up. DHHR sought its inclusion as an alternative to Wraparound under the Agreement for young adults that may benefit from either service.

ACT is not yet available statewide. The State has provided additional support to Mountaineer Behavioral Health to begin services in the eastern panhandle region, a running document recording contact between the State and the provider noted that they had been unable to obtain sufficient psychiatric coverage needed to offer the service.

The service definition included in Chapter 503, Licensed Behavioral Health Centers Provider Manual, is consistent with this Agreement definition. The manual includes requirements for fidelity (p. 45). The State has indicated it intends to update Chapter 503 in late 2022, following updates to Chapter 531, Residential Mental Health Treatment Facilities. Draft language for Chapter 531 provided to the SME in August 2022 did include the following: “Discharge planning for any members 17.5 – 21 years of age must include consideration, education and referral to Assertive Community Treatment (ACT) Program. Criteria must be reviewed and discussed with the member and/or family.”

Chapter 503, as well as Bureau of Medical Services policy manuals for CSED and residential facilities are in the process of being updated to include a freedom of choice for Medicaid members eligible for ACT services. The State anticipates training providers on the form with final updates to occur in January 2023. The SME has not yet reviewed the State’s training plan or training curriculum but anticipates doing so in the next report cycle. The State is creating an Appendix to Chapter 503 in late 2023 to early 2024 which will describe requirements for Certified Community Behavioral Health Centers (CCBHCs). CCBHCs will be required to support or contract with at least one ACT team. The SME anticipates reviewing this Appendix and other changers to Chapter 503 as they become available and as the State makes progress on its related State Plan Amendment.

1. The SME notes that this strategy may increase the availability and timely accessibility of ACT but recommends that the State begin planning for psychiatric workforce shortages and

consider how it will avoid increasing competition for its limited provider pool between varying provider types, including CCBHCs, ACT, and other HCBS.

2. In addition, to achieve compliance with the Agreement’s provisions on timely access, the SME recommends that the Bureau for Medical Services amend or update the eligibility criteria for ACT in Chapter 503. As currently written, eligibility is limited to those with three or more hospitalization in a psychiatric inpatient unit or hospital in the past 12 months; five or more hospitalizations or admissions to a community psychiatric supportive treatment program in the past 24 months, or 180 days in a psychiatric inpatient unit in the past 12 months. The Bureau is permitted to authorize services for members “who exhibit medical necessity” and several examples follow. The SME recommends the eligibility criteria for ACT in Chapter 503 be explicitly expanded to include youth, including those who are being discharged from residential treatment. This inclusion will make it abundantly clear that youth are eligible for such services.
3. The SME notes that the State is increasing the frequency of retrospective review. As per a draft memorandum, beginning Jan. 1, 2023, the State intends to review ACT providers on a 12-month cycle, rather than the previous 18-month cycle. This annual review will include 100% of ACT recipients between the ages of 18 and 21; this is a significant increase over the 20% current sampling and will give the State a more accurate understanding of the provision of this service to the relatively small number of young people who receive it. The SME commends the State for this change and anticipates reviewing findings in future report cycles to ensure that services are appropriately individualized, including the amount, duration, and location of services.
4. The Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document) (hereinafter “CQI Plan”; dated Sept. 9, 2022) includes several measures related to ACT including referrals and referral source, service utilization, length of service, and provider capacity. The SME commends the State for this updated document which contains greater specificity and will assist the State in demonstrating compliance with the Agreement requirements. However, the data sources listed do not include the Children’s Crisis and Referral Line even as it is the main resources listed on the Kids Thrive website. In addition, it appears the State lacks firm data sources for (1) referral source (it is listed as “under discussion”) and eligible youth over 18 offered a choice of ACT versus Wrap (it is listed as “Kepro Quality Review Tool”). The SME recommends the State determine which data source(s) provide the most accessible, accurate, and timely data while reducing administrative burden.
5. DHHR (both BMS and BBH) continued efforts to secure a provider for Region 2, the Eastern Panhandle, one area of the state without an ACT provider. A provider has agreed to serve that region but will not begin services until 2022 due to expected recruitment, hiring timeline, and necessary training of the hired Team in the ACT model before enrollment of youth and service provision can occur. BBH sought and received approval from SAMHSA to use block grant dollars to provide start-up funding for that provider. DHHR indicates that a specific start date

will be determined by the end of summer. Additionally, since the selected provider already provides ACT services in another area of the State, BMS has granted a waiver allowing the provider to enroll up to 50 youth immediately, depending on their staffing levels versus new ACT providers who are only allowed to enroll 20 clients. DHHR has asked other providers to conduct outreach and refer to other appropriate services and is gathering a list of potential list to refer to the service when it is available. The SME notes DHHR's efforts to secure a provider for Region 2, an area of the State in which it is difficult to attract providers, the coordination across BMS and BBH to coordinate training, secure start-up funding for the provider, and proactively provide a waiver to increase the numbers of youth that the provider can serve once they begin services.

Agreement Requirements 24, 25, 26, 27, 28, 40, and 41, Compliance Rating: Partial Compliance

The State's Youth and Caregiver Survey, conducted in partnership with West Virginia University, reveals the need to provide families and youth with additional information on ACT. According to the survey results, only 16% of caregivers representing 19 youth had heard of ACT and only 24% of youth had heard of it, with less than 10% using it in the past 12 months. The survey notes that "few [youth] would have been old enough to be eligible and/or would have used Assertive Community Treatment during the baseline year" but that "a large percentage of the sample (77%) are or will be eligible within a few years."

1. To that end, to provide families and children with accurate, timely, and accessible information, the SME recommends the inclusion of information on ACT in the State's Resource Rundown; a plan to verify that the Children's Crisis and Referral Line (listed on the KidsThrive website in response to the questions "How do I get my child connected to home- and community-based services, or get a mental health assessment for a child or youth in West Virginia? How do I get help with de-escalating a child's behavior? How do I get help with a mental health referral to therapy in my home or community? How do I get Wraparound services? Contact the Children's Crisis and Referral Line at Help4WV or call (844) 435-7498") is providing information about ACT as appropriate for families with older children and youth; and a clear engagement strategy that incorporates learnings on discharge reason consistent with the recommendations of the Quality Review Committee.
2. In our previous report, the SME recommended that the State clarify how youth eligible for ACT and Wraparound would be offered choice of the two services and referred to the selected service. A coordinated effort across workgroups has occurred to develop a single, common pathway for access to all services. In this draft pathway document, the team has focused attention to how youth would be determined to meet eligibility for either service, and how a youth eligible for both, would be offered choice and referred to ACT or Wraparound. While documents such as standard operating procedures, policies, guidance to providers, and expectations for Medicaid MCOs and ASO are not yet developed, the State indicated such documents will be developed and submitted in the coming months. The State has confirmed that the pathway will include offering youth a choice between ACT and Wraparound when eligible for both. The SME recommends these documents be finalized and implemented.

Under contract with the State, the State's ASO, KEPRO, conducts fidelity reviews of the ACT service annually. Reviews are conducted in a rolling fashion across an 18-month cycle from initiation to completion of the reports. Fidelity monitoring tools used by KEPRO were provided to the SME including the ACT Review Tool, a mock-up of a summary report of all ACT providers reviewed listing their scores for each element from the review tool, and a redacted ACT provider-specific report summarizing KEPRO's findings from its review of that provider, including recommendations to improve quality. BMS indicated plans for provider workshops twice per year to meet with providers across the State, such as inpatient facilities, residential programs, and community mental health providers, to explain ACT service and support referrals to the service with virtual meetings being used during the pandemic. The SME understands that the State is developing a policy document for residential providers, which will include information about accessing ACT for older youth transitioning back to the community.

3. The SME notes the quality review process in place to monitor fidelity to the ACT model, and provider-specific reports that note strengths and areas for improvement. This type of monitoring is critical for each of the DOJ Agreement services and can serve as a model for similar approaches to other services. The SME recommends continuing on this current path.
4. Regarding which youth are referred to ACT or Wraparound, once the assessment pathway work is complete, DHHR will need to finalize a SOP describing how a member will be offered choice between ACT and Wraparound and to develop an oversight plan, including data that will be collected and describing how DHHR will monitor that choice is being provided to youth.

Quality Assurance and Program Improvement (QAPI)

Agreement Requirements 31, 34, 40, 41, 42, 48, 49, 50, 51, 52. For all children, screened, assessment and receiving services under the Agreement, the State is required to collect and analyze data to provide an assessment of service delivery, including whether children are unnecessarily institutionalized, measurement of improved positive outcomes, decreased negative outcomes, changes in functional ability, fidelity to National Wraparound Initiative model, and timeliness of crisis/urgent services. The Agreement requires the State to perform quality sampling reviews of a statistically valid sample to identify areas of strength and areas for improvement, with related steps for improvement in a semi-annual report. In addition, it requires (1) that 52% of Medicaid-eligible children who are not in the Youth Services, child welfare, or juvenile justice systems be screened with the mental health screening tool annual and (2) the State to achieve a reduction in the number of children living in Residential Mental Health Treatment Facilities (RMHTF) to 25% reduction from the 6/1/2015 census by as to 822 by December 31, 2022, with subsequent reduction to 712 youth by December 31, 2024.

Activities

The SME wishes to acknowledge at the outset that the State has made tremendous strides in their quality assurance and program improvement (QAPI) activities. The State hired a Director for the Office of Quality Assurance (OQA) for Children's Programs. This OQA has undertaken significant activities to improve the State's data culture, with careful attention to key performance indicators, defining numerators and denominators, and establishing cross-bureau collaboration which includes beginning to aggregate data across bureaus and payers. The Office has completed three rounds of Quality

Committee reviews (Nov./Dec. 2021, May 2022, and Aug. 2022) to improve the quality, accuracy, and timeliness of data across agencies (BSS, BBH, BMS, BJS). It also produced a timeline of project rollout for the data store/dashboard through April 2024. Additionally, the OQA and the bureaus are working to define clear roles, functions, and responsibilities respective to each for data review, identification of themes, and the design and implementation of quality improvement tasks.

As a result of this and related efforts, the July 2022 semi-annual report now includes data on the Assessment Pathway, Bureau of Juvenile Services screening, Probation Services Screening, and prioritized discharge planning. The OQA worked with BerryDunn, the State's contractors, to respond to previous recommendations to improve the State's Key Performance Indicators (KPIs) to add frequency of data review, name the person or entity responsible for review, new indicators, and a schedule for publishing program-level quality review reports. The semi-annual report has improved its data specificity by stratifying data by race, ethnicity, and geography. The State is also laudably including in its data reporting where data did not align with current policies and practices (e.g., when the CCRL was not able to complete a warm hand-off to the CMCR) and indicated considerations for future analysis. DHHR indicates that the next semi-annual report (due Jan. 2023) will reflect new metrics that will be available including:

- CSED Waiver Length of Service and Utilization throughout Life Cycle of Services
- Marshall Wraparound and CANS Fidelity Results
- Child Functional Outcomes (per CANS results)
- Qualified Independent Assessment Data
- Youth Services and Child Protective Services Screening Data
- Outreach Data
- Provider Capacity

DHHR has developed a thorough, detailed roadmap for the creation of a data store that will house data specific to this Agreement. The roadmap describes a phased approach for adding data elements over time with work expected to be completed April 2024. This plan also specifies when certain measures described in the Continuous Quality Improvement Plan, or required in the Agreement, will be available for DHHR reporting.

The State, in collaboration with West Virginia University, revised its March publication, System and Community-Level Evaluation, in June 2022. This report includes baseline data collected July 2021 to February 2022 that includes over 1,400 providers, facility staff, and partners, 49 interviews of key informants, and 36 focus groups.

DHHR has developed a Data Dashboard, which will be used internally by DHHR personnel. The Dashboard will be developed in phases, as data is available in the data store. The State, in partnership with BerryDunn, developed its *QAPI Dashboard System User Guide – Phase I* with its Phase I Dashboard Indicators for children in state custody or parentally placed.

TABLE 12: PHASE ONE DASHBOARD INDICATORS FOR CHILDREN IN STATE CUSTODY OR PARENTALLY PLACED

	Description	Dashboard Page
1.1	RMHTF unduplicated head count	1.1 – Head Count
1.2	RMHTF average monthly bed utilization	1.2 – Bed Utilization
1.3	RMHTF average length of stay (ALOS)	1.3 – ALOS
1.4	RMHTF count of new admissions	1.4 – New Stays
1.5	RMHTF number of prior placements in an RMHTF	1.5 – Prior Stays
1.6	RMHTF number of exits from RMHTF by exit reason	1.6 – Exit Reason

For this report, DHHR provided the SME with eight screenshots of its Internal QAPI Dashboard that included various metrics specific to residential stays, county of origin, and demographics. For the DHHR user of the dashboard, the dashboard includes dropdown lists that allow the user to narrow or expand its review by certain fields (e.g., county vs. statewide, demographics, service type.)

Related documents produced and review by the SME include the Phase I SSIS Project Operation and Maintenance Manual, the Deployment Guide, database documentation, external source data, and data extract specifications.

Data on National Wraparound Initiative Fidelity and CANS fidelity from Marshall University is being collected and analyzed in the fall and winter of 2022 with results to be included in the January 2023 semi-annual report. The State is partnering with West Virginia University to complete the quality sampling reviews. The child and caregiver survey evaluation report was delivered in September 2022 and was scheduled for review in DHHR’s Quality Committee review for October 2022 with results to be included in the January 2023 semi-annual report.

DHHR is convening a meeting Fall 2022 with Homeland Security, Education, and Court System to discuss data sharing and data metrics required for this Agreement. DHHR indicated progress on data sharing and timelines will be shared in the next semi-annual report.

The SME notes that in the semi-annual report and in other data shared for this report, significant portions of data are missing (e.g., 28% of children’s records lacked data on time to complete CSED waiver application after referral; 83% of race data were missing from the CCRL; 29% of timeliness data on warm transfer to the CCRL; 29% unknown referral source for CCRL)

Data trends are beginning to emerge that flag for quality issues where data is at odds with national prevalence or are potential data quality issues such as the high rates of cyclothymia and schizoaffective disorder diagnosed among the target population or where high rates of CMCR calls are resolved within one telephone call, waiver eligibility but failure to access any waiver services; low utilization of the CSED waiver’s home- and community-based services; similar service utilization profiles of children enrolled in the waiver (which may or may not suggest a lack of individualized care planning); and the continued placement and lengths of stay of children with low CAFAS scores, as detailed in the August Quality Committee slides.

Compliance Ratings and Recommendations

Agreement requirements 41 and 49, specific to the implementation plan, are not rated. The Implementation Plan revision timeline occurred after this report cycle. DHHR, DOJ, and the SME are scheduled to discuss the implementation plan and provide comment by the end of November. The SME's April 2023 report will address the implementation plans compliance with the Agreement.

Agreement requirements 48, 49, 50, 51 are specific to the development of a Quality Assurance and Performance Improvement system, required data elements, development of a dashboard, production of semi-annual reports, quality sampling, and steps to improve services and address problems identified. **Compliance rating: Partial Compliance**

The SME finds considerable progress made in this area, including developing a thorough Quality Plan, including key performance metrics that will be tracked, and a defined process, and related procedures for quality oversight and improvement (the State and its partners are producing data reports and expect reports generated from the data store to be available by April 2024); developing a through roadmap for the development of its data store and described the timeline for when required elements of the Agreement will be reported, in a rolling fashion, through April 2024; providing semi-annual reports on its progress; indicating that quality sampling activities are underway and will begin to be included in the next semi-annual report; and developing a data dashboard for its internal use with initial metrics available and plans to add metrics as the data store is developed.

1. Specific to DHHR's quality plan, quality oversight, and quality improvement processes, to continue to maintain partial compliance and to achieve full compliance, the SME recommends that the State commence with selected rapid cycle quality improvement practices with at least one rapid cycle improvement project per service area of the Agreement. DHHR is now at the stage in its quality oversight structures, to prioritize and implement rapid cycle improvements. The SME recommends that at a minimum, the following areas be addressed in rapid cycle improvement within the next year:
 - a. QAPI – The August 31 Quality Committee slides include data on RMHTF census, acuity (CAFAS/PECFAS scores below 90), diagnosis; similarly, the semi-annual report includes such data. Slide 39, RMHTFs – Discharge Planning: Discharge Plan Status, shows that more than half of children in RMHTFs over the months presented did not have a discharge plan, data was missing, or “unsure” (“unsure” was not defined). These data are a clear barrier to achieving full compliance with the Agreement (reducing residential census) but the KPI – which the SME acknowledges is a working document – has a measure on “quality and appropriateness of discharge plans” that lists data needed and frequency of review as “to be determined.” The data source is listed as “future vision” to discuss Aetna/Mountain Health Promise's quality review process for discharge plans based on Council on Accreditation Standards.
 - i. The SME recommends that DHHR begin refining its data collection tools to remove data point, descriptions, and fields that do not provide actionable information, are vague, or unclear. For example, “unsure” does not provide the State with any information regarding the child or youth in residential. The State should begin reviewing current data collection tools to ensure that the data fields/options for responders are as precise as possible to ensure consistent reporting; this review

should remove extraneous fields and/or add fields that will assist the State in learning more about each service category. By disallowing vague or unclear fields, the State will improve the quality and consistency of the data collected over time.

- b. CMCR
 - i. A review of CMCR calls that are resolved with one telephonic support to ensure that the intervention met the needs of the youth, and met program expectations for providing CMCR; and
 - ii. A review of CMCR callers that have multiple calls to the CCRL or CMCR provider to ensure that the intervention received met their needs, and of persons with multiple calls were recipients of telephonic support only; and to ensure connection to community services.
 - c. Assessment Pathway
 - i. A review to understand opportunities to reduce timeline between referral and time of first service; opportunities to reduce the numbers of children who initiate CSED waiver but do not complete the process.
 - d. Residential
 - i. A review of children in RMHTF to ensure that all children have individualized discharge plans.
2. In addition to rapid cycle improvement projects, the SME recommends that certain data elements need to be reviewed in real-time, either daily or weekly in addition to scheduled monthly, quarterly, or annual Quality Committee reviews to ensure that basic contract requirements are being met.
 - a. BBH should receive daily notification from CCRL when a warm transfer attempt to a CMCR provider did not occur so that BBH can follow-up with the provider and determine any appropriate resolution. These daily or weekly management activities that incorporate certain real-time data would be described in future semi-annual reports.
 3. The SME recommend the OQA and relevant bureau(s) select a small number of data indicators that are particularly concerning and begin daily or weekly monitoring. For example, only 41% of the individuals who called the CCRL for whom the call was reported as “emergency/crisis/urgent” were directly transferred to a mobile crisis team via warm transfer. In this example, the Office and Bureau would receive a daily log of calls that were recorded as “emergency/crisis/urgent” but failed to warm and timely transfer to CMCR. Receiving this information promptly will allow the appropriate Bureau to provide contract management and quality oversight, while ensuring that the Office is aware of themes and trends and is supporting a consistent quality improvement approach across DHHR.
 - a. The SME further recommends that the State review the infrastructure and resources currently available to the OQA are sufficient with current and projected tasks, including the proposed rapid-cycle review. The SME appreciates this is a new office that is still building its staff expertise; as such, we encourage all parties to be thoughtful and planful about prioritization of rapid cycle and other performance improvement projects.
 4. As DHHR’s data sources grow, it will be important to clearly identify specific metrics. This includes selecting an accurate data source and defining the numerator and denominator of each metric to ensure it is accurately and consistently reported and analyzed by the State and for inclusion in future SME reports. As noted, we expect the State to collect multiple measures; varied metrics are

expected, especially as an entity is grappling with how best to analyze and report on a significant amount of newly collected data. To ensure a consistent understanding of the State's progress on compliance across reports, identifying the specific metrics that will be examined and included to measure progress over time is important.

5. The SME recommends that the State review its managed care/vendor contract requirements to assist it in meeting the Agreement requirements. The State's KPIs list an annual review of MCO/vendor compliance but no additional details; data needed, data source, report name, and guidance for review are all listed as "to be determined." As the State is shifting its data culture, so too must it shift its accountability and oversight mechanisms for its vendors to assist it in achieving compliance. The OQA is relatively new and bearing significant responsibility for understanding data and using it to demonstrate compliance. To avoid overburdening the Office, we recommend the State undertake a review to ensure that vendors and contractors are meeting their programmatic and reporting requirements and consider whether current contractors are sufficient to assist the OQA and DHHR in accomplishing its goals.
 - a. For example, as KEPRO, the ASO, begins performing qualified independent assessments of children who are at risk of residential placement or referred to residential placement or shelter care, how the collection of related data by KEPRO is most useful to the State at what frequency or interval, as well as processes for verification, oversight, and monitoring.
 - b. The MCOs has contractual obligations to improve EPSDT screening rates but information about BMS oversight and efforts to improve screening rates has not been shared for the SME to reflect in this or previous reports.
 - c. Similarly, as DHHR collaborates with Mountain Health Promise (MHP) to prioritize discharge planning, how it ensures that MHP care managers are using that information timely and improving data collection on barriers to discharge.
6. The SME recommends that the State begin reporting data by child in addition to by-service, by-agency, or by-payer. While the State has made considerable progress in reporting by-service, it is difficult to discern the range, types, and amounts of services children are receiving, or the complete timeline of access from initial request or referral to screening to assessment to first service provision. The semi-annual report and other State documents do record timeliness largely in siloes; only through manual calculation can we see that significant delays are occurring as a child moves along the Assessment Pathway (e.g., the mean 58-day delay between determination of waiver eligibility and the first provision of Wraparound facilitation).
7. Following its meeting with Homeland Security, Education and the Courts, DHHR will revise its Quality plans, KPI metrics and timeline to address data elements required under Requirement 49d "including: whether they have been arrested or detained without being charged, have been committed to the custody of the Division of Juvenile services or the Department of Health and Human Resources, have been suspended or expelled from school, and have been prescribed three or more anti-psychotic medications."
 - a. The semi-annual report notes that DHHR has started discussions with the Division of Probation Services to establish reporting of juvenile petitions filed but has not yet determined a data source.

- b. Similarly, DHHR is collaborating with the Department of Education to evaluate child-level data on suspension and expulsion. The SME notes that the Department of Education is [reporting data](#) on suspension and expulsion already and encourages it consider data sharing agreements.

Section Two: Progress on Meeting DOJ Agreement Requirements and SME Recommendations:

Workforce

CSED Waiver

Behavioral Support Services

Therapeutic Foster Care

Outreach & Education

Residential Interventions

Workforce

The Agreement requires the State to take steps to (1) address workforce preparedness to deliver services; (2) ensure availability of sufficient providers; and (3) address any workforce shortages. Inherent to fulfilling the Agreement is the need to identify and implement strategies to understand current capacity, as well as to recruit, retain, train, and coach a behavioral health workforce to understand West Virginia's vision for reforming its system and deliver services to children and families consistent with this Agreement.

Activities

DHHR has focused its efforts to ensure sufficient capacity of workforce in three primary areas:

1. Preparing the Workforce
2. Analysis of Workforce
3. Incentives to Workforce

Regarding preparing the workforce, each service specific section of the report describes DHHR's efforts to prepare the workforce for offering services under the Agreement. DHHR has invested considerably in the development of infrastructure to train, coach, and assess skills to meet the needs of assessments incorporating the CANS, Wraparound, CMCR, and BSS. Also, as noted in the residential section, DHHR is partnering with Casey Family Programs and Chapin Hall, to promote practice change among residential providers in order to improve the quality of care youth receive. The SME directs the reader to relevant service sections for current DHHR activities specific to training, coaching and fidelity/skill acquisition.

Regarding analysis of Workforce, DHHR had prioritized understanding capacity to provide Wraparound services. DHHR has developed a detailed, multi-tab Excel spreadsheet tracking individual Wraparound facilitators by bureau (BBH, BSS, BMS CSED), the number of children served by each facilitator across funding bureaus, and by the child's county of residence. Data across bureaus also allows DHHR to see where capacity is shared across bureaus (when a provider serves more than one bureau). Collecting data across bureaus is an important data metric and the SME commends DHHR for including it. This way, as wraparound facilitators work across providers or bureaus, the overall numbers of youth and families they are working with is clear.

Table 12, below, shows June 2022 redacted provider information summarized at a provider level for the number of youth enrolled in Wraparound, by bureau. This is an example of the type of information now available to DHHR, allowing it to view, by provider, the specific facilitators, the number of youth each provider is serving, the funding bureau, when an individual facilitator is working with children across multiple bureaus or providers, and the county where a child resides.

This data allows DHHR to understand overall numbers of youth assigned to each provider, and coupled with providers' staffing information, allows DHHR to see a snapshot of Wraparound facilitator availability across its system. In addition, at a provider level, this information informs opportunities to align DHHR policy that all Wraparound providers will become CSED Waiver providers. As of June, there were 16 provider agencies offering Wraparound across the three bureaus; three provider agencies were offering Wraparound services across all three bureaus, two are providing CSED and SAH Wraparound funded services, one provider is offering CSED and BBH funded Wraparound services, five are only offering SAH funded Wraparound services, four are only offering CSED Waiver funded Wraparound

services, and one is only offering BBH funded Wraparound services. This data highlights that six providers, as of June, were not offering CSED Waiver Wraparound services.

TABLE 13: ACTIVE WRAPAROUND ENROLLMENT, BY PROVIDER AND AGENCY

Provider	BBH	SAH	CSED	Total
A	34	63	78	175
B	-	56	98	154
C	-	147	-	147
D	-		135	135
E	-	129	-	129
F	3	68	14	85
G	--	77	-	77
H	-	64	-	64
I	-	36	28	64
J	20	9	11	40
K	39	-	-	39
L	-	-	32	32
M	18	-	10	28
N	-	21	-	21
O	-	-	14	14
P	-	-	12	12
Grand Total	114	670	432	1216

In addition, the spreadsheet summarizes ratios of youth assigned to each facilitator. The SME recognizes DHHR’s report of an overall average of one Facilitator for seven youth, calculated by dividing the total number of youth (n=1216) by the total number of Facilitators (n=165). The SME notes that 112 had less than a 1:10 ratio; 19 had a 1:10 ratio, and 34 exceeded the fidelity capacity with ranges of 11-24 youth. The data also tracks youth not yet assigned to a facilitator; as of June 2022, 24 youth were not yet assigned. The SME commends DHHR for collecting this data and notes the considerable opportunity it provides DHHR to understand where capacity exists, where there is a need to add additional capacity (when using as a proxy where Wraparound facilitators are assigned more youth than the fidelity ratio), and where alignment with national Wraparound fidelity standards exists. The SME recommends that DHHR examine assignment of youth similarly moving forward to understand where capacity issues exist.

In addition to DHHR’s priority to understand capacity to provide Wraparound, DHHR submitted to the SME for this report a spreadsheet *Plan to Assess Service Capacity & Workforce* (Sept. 8, 2022). This spreadsheet defines DHHR’s plan to assess capacity to meet all services under the Agreement. It describes the assumptions for the analysis including:

The services of focus are i) all Medicaid services authorized and enabled by the CSED Waiver, including, but not limited to, waiver case management that has an alternate title of wraparound facilitation & mobile crisis response, ii) IV-E Therapeutic Foster Family Care placement support, III) and the Medicaid state plan service of Assertive Community Treatment (ACT).

The document lays out an orderly ten-step process to finalize the capacity analysis including analysis of active client counts for CSED services, ACT, and residential; and qualifying utilization based on current utilization in CSED Waiver, residential, ACT, with forecasting need based on these findings to develop a model staffing plan and close any gaps to meet that expected demand.

In the document, *Response to the April 2022 SME Report*, DHHR indicates that this capacity analysis will include data from the May 2021 State Occupational Employment and Wage Estimates compiled by the US Bureau of Labor Statistics, and that it is assessing waitlists and timeliness data for other community-based services.

The SME notes that discussions with DHHR about the document and planned methods have not occurred by time of this report. As such, the SME looks forward to discussions with DHHR to ensure the following considerations: plans to account for low utilization and low enrollment figures in the data sources, inclusion of other behavioral health service utilization data outside of the CSED Waiver that could inform needed capacity such as BBH and SAH data, projecting desired use consistent with best practice, potential use of available CANS and CAFAS data, use of national prevalence estimates in the [National Survey of Child & Adolescent Well-Being](#).

Regarding incentives to the workforce, as mentioned in our April 2022 report, West Virginia implemented a [loan repayment program](#). This loan repayment program addressed several behavioral health priority areas including child psychiatry and children’s mental health clinicians. Our previous report, April 2022, described the first award cycle with 23 early career practitioners; and a second award with another 23 early career practitioners has since occurred. BBH is actively pursuing additional funding and plans to offer another loan repayment cycle once funding is secured.

The SME April 2022 report included a summary of ARPA funded efforts. The SME received an update on those efforts in a document, *WVU ARPA Projects Update September 8, 2022*, included in the SME-developed table, below. While these efforts are not specific to children’s behavioral health or tied to specific services in the Agreement, these investments are inclusive of children’s behavioral health providers, DHHR personnel working with children and families, and other disciplines which encounter children and youth (e.g., police.)

TABLE 14: WORKFORCE-RELATED ARPA FUNDING INITIATIVES

#	Title	Purpose	Dates	Status (Sept. 8, 2022)
1	Medicaid Home & Community Based Services Public Education & Outreach	Develop a plan for a public education initiative regarding West Virginia Medicaid Waiver programs to potential recipients of Medicaid waivers	11/15/21-3/31/22	HCBS webpages were updated to improve organization and accessibility of waiver information, and additional resources for caregivers. Direct outreach efforts are in process to target individuals that may qualify for the Waivers, including the CSED Waiver.
2	Integration of a Person-Centered Trauma Informed Approach for Medicaid Home and Community Based Services Front Line Workers	Develop a plan for Patient-Centered Trauma-Informed Care Trainings	11/15/21-3/31/22	Medicaid home and community-based service direct service professionals (training for how to respond to clients’ reactions or symptoms that have trauma-related origins.

3	Evaluation of ARPA Home & Community Based Services Workforce Training and Public Education & Outreach Initiatives	Evaluate the plan for Outreach & education (#1) and Plan for patient-centered trauma informed care (#2)	11/15/21-3/31/22	Input from personnel to inform needed training; feedback will be incorporated into training plans.
4	Medicaid Home & Community Based Services Workforce Training Curriculum and Learning Management System Update	Develop a plan for Medicaid -waiver requirements training to be transferred to BMS's internal Learning Management System (LMS)	11/15/21-3/31/22	Input from personnel to inform needed training; feedback will be incorporated into training plans.
5	Safe Interactions for Law Enforcement and Persons with Intellectual or Developmental Disabilities and Mental and Behavioral Health Disorders	Develop a plan for training law enforcement regarding interactions with persons with behavioral health or IDD needs	11/15/21-3/31/22	Officers are being trained on safe interactions with members of the public with Autism Spectrum Disorder and other IDD's; and provided with statewide resources to utilize if they encounter an adult or child in crisis.
6	Mindfulness Based Resilience Training for Front Line Health Workers and Law Enforcement Personnel	Multiple activities including: 1. Enroll 200 law enforcement and front-line workers into training Mindfulness Based Resilience Training 2. Train 20 people to serve as Peer Coaches to support regionally based teams 3. Evaluate effectiveness of training	11/15/21-3/31/22	Training to support frontline workers and law enforcement personnel with positive coping strategies to regulate negative emotions viewed as precursors of burnout.
7	Developing a Trauma-Sensitive Workplace	A multi-year investment to develop a plan and initiate training to address secondary traumatic stress for workers, supervisory skills to support staff; address critical incidents.	4/1/22-3/31/24	In partnership with MU, survey of staff in October 2022 and every six months thereafter, critical incidence response training January 2023, peer support March 2023 and staff training beginning December 2023. The SME commends DHHR's attention to this important workforce issue.

Recommendations

1. Although not repeated in this section, the service specific sections describe the considerable investments DHHR has made regarding preparing the workforce to provide Agreement services. The SME recommends that DHHR continue this path, and begin to develop more advanced training, or modifications to existing training, based on DHHR learning from the

rapid cycle improvement priorities identified in this report; feedback from provider evaluations; youth, parent, stakeholder, and provider insights learned through the WVU evaluations, and DHHR's quality and fidelity reviews.

2. Specific to DHHR's plan to assess service capacity, the SME acknowledges DHHR's new document *Plan to Assess Service Capacity & Workforce, September 8, 2022*. The SME looks forward to discussions with DHHR to ensure inclusion of:
 - a. Methodology that uses DHHR's target population methodology (as discussed in the Target Population section of the report). This would include examining children, and their related services that meet the target population definition, and captures children in that might not otherwise be receiving CSED or residential services;
 - b. Methodology that compensates for known low service utilization (intensity of services) and known low enrollment in the Waiver;
 - c. CAFAS and CANS data which does capture need;
 - d. Trends in the Administration for Children and Families' [National Survey of Child & Adolescent Well-Being](#) that indicate national prevalence rates; and
 - e. DHHR expectations for how each service should be delivered. For example, current CSED Waiver does not show practice according to national fidelity data or even DHHR's service description for the number of touchpoints with a family receiving Wraparound. This data would need to be included for all services, drawing upon fidelity data when available, or estimates of number, frequency, and duration of service contacts consistent with DHHR defined service specifications.
3. Specific to its ongoing Wraparound Facilitator capacity, DHHR has made significant efforts to develop the Wraparound Facilitator capacity data. This data is a vital component to ensure sufficient Wraparound capacity across bureaus, and by individual Wraparound facilitator.
 - a. The SME recommends that DHHR continue its path to monitor Wraparound Facilitators caseload and capacity.
 - b. The SME recommends that DHHR also analyze and report on more than an overall Facilitator average. For example, instead of averaging 1,216 youth across the 166 Facilitators which shows an average 1:7 case ratio, group data by the numbers of Facilitators below the 1:10, at 1:10, and exceeding 1:10 which then provides more actionable information.
 - c. The SME recommends that the DHHR implement a rapid cycle improvement effort specific to emerging quality issues and policy opportunities that are evident from the data such as reducing the number of facilitators with ratios that exceed quality standards.
4. Regarding its recent ARPA-funded investments, to continue its planned path to incorporate the content, outcomes, and findings into ongoing DHHR procedures and trainings. Specifically regarding its ongoing effort through 2024 to address trauma sensitive workplace, the SME recommends ongoing updates on this effort including its plans to modify or expand this effort based on its learning.

5. The STLR initiative is an important investment to build and retain qualified personnel. The SME recommends that DHHR continue its current path to secure funding for loan repayment as part of an ongoing workforce strategy. In addition, the SME recommends that DHHR consider other workforce enhancement strategies including:
 - a. Working with its state licensing boards to broaden scope of practice language in order that practice-based expertise, training, and other education can be recognized;
 - b. Development of a certification program for persons with relevant work experience to be credentialed /deemed qualified to provide certain services including serving as a Team member on CMCR, working as a Wraparound Facilitator, providing BSS services, and serving as a Team member for in-home therapy approaches;
 - c. Develop a supervisory infrastructure to support effective supervision such as [New Mexico's Clinical Supervision Implementation Guide](#);
 - d. Assess current workforce that only accepts third party insurance, and address any refusals to accept Medicaid beneficiaries; and
 - e. Work with West Virginia colleges and universities to develop curriculum and graduation requirements that prepares the future workforce to provide HCBS services upon their graduation such as CMCR, Wraparound, and BSS.

CSED Waiver

Activities

BMS received approval from the Centers for Medicare and Medicaid Services (CMS) to amend their 1915(c) waiver. The waiver amendment was approved July 1, 2022, and includes the following:

- a permanent expansion of the Medicaid eligibility group;
- a permanent expansion of the eligible degree types for providers to include non-licensed clinicians delivering services under the supervision of licensed providers for G0176 HA Extended Professional Services and H0004 HO HA Family Therapy;
- extend the timeframe an eligible member must begin receiving HCBS before an unused waiver slot is discharged from 180 days to 365 days;
- adjust the numerator for performance measure A-ai-7 (Number of authorizations denied. Numerator - Number of authorizations approved. Denominator - Number of authorizations requested) for clarity;
- remove the “in-home” requirement for Family Therapy to increase service setting options to align the waiver with the State’s wraparound initiative;
- add Evidence-Based Therapy requirements to align with CMS and evidence-based practices;
- update the conflict free case management service radius from 25 miles to 15 miles to increase access to HCBS; and
- updating BCF (Bureau of Children and Family) to BSS (Bureau of Social Services).

BMS provided the SME with three pages of public comments related to waiver changes. One commentor asked if the evidence-based therapy would be those deemed so as part the Family First Prevention Services Act’s Clearinghouse; the State clarified that “[e]vidence-based practice requirements for the CSED Waiver are not related to Title IV-E funding initiatives.”

Aetna, which operates Mountain Health Promise, provided a training to 67 Department of Juvenile Services Probation Officers in February and March 2022. Psychological Consultation & Assessment, Inc. (the Independent Evaluator Network (IEN)) conducted an information course for clinicians who might be interested in joining the IEN.

BMS shared its finalized but not yet distributed or disseminated *Wraparound Manual*, dated September 12, 2022, which includes information on how to access Wraparound services via the waiver (see, e.g., Section 3.0, West Virginia Wraparound Services and Section 4.0, How to Access Wraparound Facilitation). In addition, in responding to prior SME recommendations, the State provided data on enrollment and service utilization by hour rather than by billable unit. This enhances clarity in parsing which services children and youth are receiving with what frequency. The Bureau also created a two-pager on the CSED waiver for outreach and education purposes.

In partnership with West Virginia University, the State conducted a youth and family survey and produced a related evaluation report. Although slightly more than half of caregivers and one-quarter of youth reported awareness of Wraparound, one of the waiver services, “[c]aregiver participants conveyed a strong need and desire for community-based services upon discharge, particularly median-tier, and more specialized service options (namely therapy or counseling) tailored to youths’ complex needs to sustain the transition home and deter future residential placement... Half of the caregivers and several youths who responded to surveys reported challenges in starting services. When challenges were encountered, long wait times were a commonly reported barrier... Caregivers described in-state services as “nonexistent,” with limited options and long wait times for access.” The SME wishes to caveat the report as a baseline by noting that survey participation by caregivers and youth was quite low (104 and 115 completed surveys, respectively).

Using data drawn from the July 2022 semi-annual report, 245 children accessed CSED waiver services through March 2022. For the July through December 2021 received 277 applications. Even as applications increased by 70% for the July 2021 through December 2021 period compared to the January through June 2021 period, the time from eligibility determination was reduced from an average of 68.3 days to 34 days.

Table 14, below, records the waiver services by service type each child received from July 2020-December 2021. We recommend the State track and calculate average service hours per child, per month for each category and for each child across all Waiver services. Such calculations will assist the State in understanding the relative frequency and intensity of services provided for each child over time and watch for trends that could assist or challenge the State in its efforts to service children and families in the home and community rather than institutional settings.

TABLE 15: DHHR SEMI-ANNUAL JULY 2020-DEC. 2021 WAIVER SERVICES, BY TYPE

July 2020-December 2021 Totals	Total Hours	Unique Children	Hours per Child
Service Description			
CSEDW Assistive equipment	631	9	70
CSEDW Wraparound Facilitation	4,541	220	21
CSEDW Community Transition	593	1	593

CSEDW In-home family Support	4,260	135	32
CSEDW In-home family Therapy	6,070	193	31
CSEDW Mobile response	91	23	4
CSEDW Peer parent support	251	16	16
CSEDW Respite (in home)	1,024	22	47
CSEDW Respite (out of home)	1,008	20	50
CSEDW Spec Therapy	74	1	74
CSEDW Supported employment, individual	8	1	8
CSEDW Transport	2,893	28	103
All CSEDW Services	21,535	453	48
All CSEDW Services excluding IE	21,442	245	88

The Quality Report also included demographic on enrolled children and youth: the vast majority (74.1%) are aged 9-17 and enrollment is more heavily male (61% versus 39% female). The most frequent diagnoses associated with waiver enrollment were ADHD (48%), conduct disorder (40%), cyclothymia (26%), and schizoaffective disorders (20%) (note diagnoses are exclusive; children may have more than one hence totals may exceed 100%).

Recommendations

1. The SME recognizes that the State's data is improving and acknowledge that this last quality report reflected a previous recommendation to report data by service hour rather than unit, to provide a clearer understanding of the frequency and intensity of service provision. We recognize the ongoing efforts of DHHR to collect, analyze, report, and review data, including hiring a Director of the Office of Quality Assurance for Children's Programs. In reviewing the CSED waiver data, the SME has the following recommendations:
 - a. The State has successfully halved the time of eligibility determination from 68 to 34 days. In monitoring time to service provision, children are waiting an average of 58 days between determination of eligibility and the first provision of Wraparound facilitation.
 - i. The SME acknowledges that the Quality Committee has recommended additional review to understanding the delays in utilization and its relationship to the Assessment Pathway's Phase I implementation in October 2021. The SME recommends this review be prioritized and information shared with the SME as expeditiously as possible.
 - ii. The SME acknowledges the Quality Committee has recommended further analysis of Wraparound hours to meet contract and NWI requirements. The SME recommends the Committee shape its analysis considering the forthcoming Marshall University fidelity review (expected in November 2022) and that their actions following the delivery of that report be prioritized and information shared with the SME as expeditiously as possible.
 - iii. As in previous reports, the SME reiterates its recommendation that State (here, the Quality Review Committee) require its vendor monitor underutilization of

services, including the need for additional support or ongoing engagement to understand and access waiver and state plan services. We reiterate this recommendation considering the family and youth caregiver survey which showed low levels of awareness and familiarity with available services.

- b. The SME notes that the hours of service provided per child remain low. For example, using data from the most recent report, children are receiving less than four hours per month of Wraparound support; that figure is lower than expected given the complex needs of the children and youth enrolled in the waiver. Similarly, hours per month of in-home service, parent peer support, and respite are low and trends concerning. For example, from July 2020 through December 2021, children received about 6.3 hours per month of In-home Family Therapy. From July 2021 through December 2021, the average had declined to 5.3 hours. The State’s KPIs includes “Overall CSED Waiver Utilization and Utilization by CSED Services Type (average hours per child)” and “Average utilization throughout child’s life cycle of CSED services (by quarter).” Under “Guidance for Review” the performance indicators notes that it is the State’s intention to use these data to monitor utilization trends to identify areas that could benefit from additional provider recruitment and to consider comparing utilization and child outcomes.
 - i. The SME urges the State to review its provider recruitment and retention strategies. Thanks to laudable outreach and engagement efforts, waiver applications are increasing and with it, the number of enrolled children is increasing. The current data suggest that the existing provider pool will become exhausted in the near future as it is untenable for 12 active providers to provide intensive services to a growing number of youth throughout the state.
 - ii. The SME reiterates its previous recommendation to aggregate behavioral health utilization across all behavioral health services—both CSED Waiver and state plan—aggregated monthly and yearly—so that DHHR can understand the types of services and amount of service each child is receiving, particularly since the State asserts that services such as respite may be provided outside the waiver.
 - iii. The SME reiterates its previous recommendation to determine whether plans of care are individualized and as such children are receiving the amount, duration, and intensity of services matched to assessed need.
2. The SME recommends ongoing monitoring and reporting of families that decline the CSED waiver, and a revisiting of this issue in the State’s semi-annual reports, including any outreach or engagement activities associated with families who decline (e.g., surveys, focus groups, needs assessment).
3. As noted in the previous report, the SME commends BMS for requiring evidence-based approaches. This will ensure high-quality services are provided to children and youth. The SME recommends inclusion of this effort in ongoing updates.

Behavioral Support Services

Agreement Requirements: The Agreement requires the State to implement statewide Behavioral Support Services, which include mental and behavioral health assessments, the development and implementation of a positive behavioral support plan as part of the individualized treatment plan, modeling for the family and other caregivers on how to implement the behavioral support plan, and skill-building services.

Activities

The State has envisioned behavioral support services as both a service to be delivered to eligible youth, and as a philosophy for how providers engage and deliver other services (e.g., Wraparound, in-home therapy) to youth and their families.

As mentioned in prior reports, BBH has engaged two different contractors to support the work of behavioral support services:

1. West Virginia University (WVU) Center for Excellence in Disabilities (CED) Positive Behavior Support (PBS) Program is contracted to provide PBS services directly to children; and provide consultations to providers of other services on how to incorporate a behavioral support plan into their services (e.g., outpatient, Wraparound, CMCR).
2. Concord University is contracted to develop the Collaborative Center for Positive Behavioral Support Education Program to provide comprehensive workforce training and coaching on PBS approaches, and coordination of certification for providers.

Regarding the work of the CED, the most recent PBS data can be found in the DHHR's semi-annual which reports original and trend data from July 2020-December 2021. The overall number of youth served is 102 with a monthly average of 47 youth in July 2021 when compared to 21 youth served July 2020. Figure 43, labeled "Children and Interactions, Monthly, July 2021 – December 2021" but contains data from July 2020 through December 2021 shows what may be a seasonal variation in services, with nadirs in the early- to-mid-fall followed by increases through the winter months into the spring. Given that two-thirds of individuals receiving PBS serves are 5-12 years of age, this pattern appears to track the school year, with services ramping up near the beginning of each academic year.

According to the Quality and Outcomes Report, the most common services provided were "PBS Plan Writing (34%); Brainstorming, a service typically done with lower-need cases to provide ideas and support for families (19%); and Person-Centered Planning (16%). Intensive services were unknown for this period, with 35% of service type listed as unknown."

The Quality and Outcomes Report also notes workforce shortages (63% of behavioral support specialist positions at the CED were filled) due to attrition and medical leave, resulting in 12 children on a waitlist for services as of December 2021. The Bureau of Behavioral Health is meeting regularly to prioritize families "based on need."

Regarding the work with Concord University (CU), the SME received a brochure, Positive Behavior Support Training, dated October 2022 noting that training registration would open in late September 2022 and would be available to a maximum of 50 individuals such as "[p]rofessionals, parents,

community members and anyone that has an interest in learning how to support individuals with challenging behavioral and emotional disorders” and that “[t]his training is necessary for Behavior Support Professionals to work under specific Medicaid codes.” The training brochure included a QR code to register but unfortunately the website it linked to <https://www.concord.edu/BSS-collaborative-center>) was inaccessible and returned a 404 error.

We did receive a corrected link (<https://www.concord.edu/academics/college/department-of-education/behavior-support>) after inquiring. A list of trainings (Concord University Collaborative Center for Positive Behavior Support Trainings) was provided to the SME. The document lists five weeks of training and several training objectives. It also notes “all sections will have a pre-test and post test.”

DHHR’s efforts to add modifiers to existing Medicaid billing codes to clearly identify or differentiate and track behavioral support services from other similar services already available in the State Medicaid Plan remain ongoing. In a September 2022 presentation to the SME, the State noted that Chapter 503 was drafted and anticipated to be released for public comment in the fall or winter of 2022.

Recommendations

1. The SME notes that a waitlist remains for CED services. The SME recommends that the State analyze the data regarding children without ready access to a behavioral support professional to look for common characteristics (e.g., age, county of residence, diagnosis, language, etc.) and conduct targeted outreach to bolster training enrollment and successful completion in areas with greatest need. In addition, we recommend the State ensure that children who were waitlisted were successfully connected to other non-CED HCBS via the assessment pathway.
2. The SME recognizes that the reported utilization of behavioral support services is based on services provided by the WVU CED contract and that any behavioral support services provided through Medicaid are not yet captured. As BMS reaches its decisions regarding billing and service modifiers, the SME recommends that it receive specific changes to the provider billing manual to allow for discussion and incorporation of any SME comments before it is finalized.
3. The SME notes that CU’s contract runs until March 2023. The State has indicated that CU will receive a new grant beginning March 2023. The SME requests access to existing or planned/draft training plans and materials from 2022 and 2023, including all training curricula, trainer qualifications, pre- and post-testing materials, information on participants (type such as parent, professional, etc.; pass/fail rate) for review and discussion, and plans for participant feedback.
4. The SME again recommends that State include tracking referrals from schools and requests an update regarding progress. In the September 2022 presentation, the State noted “[d]iscussions are in process with FirstChoice regarding tracking referrals coming from

schools” but did not provide a clear timeline or progress milestones. This element is particularly important as it connects an earlier finding from Marshall University’s West Virginia Wraparound Review report which noted that 51% of referrals were from schools.

5. The SME continues to note the high percentage of missing data with more one-third of missing data and the State’s prior plans to “[a]ssess missing service indicators and provide technical assistance to provider for improved future collection.” The SME recommends that DHHR initiate a plan to improve the data.
6. Regarding DHHR’s prioritizing of youth in need who are waiting for PBS services, the SME recommends that provide its decision-making criteria for need determination. The SME recommends that such criteria consider CANS or other assessment; current services receiving, provider judgment; current or past involvement with BBH, BSS, or DJS; identified disability; school suspension or expulsion, etc.

Therapeutic Foster Care (TFC)

Agreement Requirements: The Agreement requires the State to develop therapeutic foster family homes and provider capacity in all regions and ensure that children who need therapeutic foster care are placed in a timely fashion with trained foster parents, ideally in their home community.

Activities

DHHR has finalized a description of its STAT home model documented in a SOP dated June 2022 and a contract addendum to its CPA contracts for the inclusion of STAT Homes as part of CPA responsibilities. DHHR has confirmed that nine of the eleven CPAs have executed the contract addendum, and plan to provide STAT services.

The State has defined a STAT home as a family alternative to residential placement for children requiring a behavioral health intervention. The SOP states that STAT Homes:

- Provide short-term intervention to provide a stable, family-like setting, with treatment and behavioral interventions so the child can ultimately return to their home or another family setting;
- Provide a safe environment for children with serious emotional disturbances or disorders to receive the behavioral health coordination of services they need from a high-fidelity West Virginia Wraparound Facilitator; and
- Will be accessible statewide.

Children and youth are eligible for STAT if they meet all the following criteria:

- Age 3 through 20
- In state custody
- Approved CSED Waiver participant with services already established
- Cannot be safely served in their current setting and are at risk of immediate Residential Mental Health Treatment Facility (RMHTF) placement

- May be supported and stabilized in a STAT Home with additional services and interventions in their community as an alternative to residential care
- Not an immediate danger to others or self, or a habitual flight risk which cannot be safely addressed through a safety plan/flight risk plan

The SOP states that there may only be one child in a STAT home and the duration of the placement is reviewed every 30 days. The SOP outlines the characteristics and responsibilities of the STAT Homes compared with other foster homes and details the trainings required for STAT Home certification.

DHHR is developing its training plan for the BSS field staff. The training for BSS staff will be implemented as STAT homes are brought on-board and children are identified as eligible for the homes. The SOP and contract addendum address the training expectations DHHR has for the CPAs to ready their STAT Home families to care for children and youth in STAT homes. The training plan for stakeholders is expected to be released in October. The materials will be used by the CPAs, DHHR personnel, and KEPRO.

DHHR notes that the STAT Home model is designed to be implemented alongside the tiered model of foster care in West Virginia; it does not take the place of Tier II (Treatment Foster care) or Tier III (Intensive Treatment). Children in these settings may be evaluated for STAT Home eligibility if there is an indication of an “imminent disruption” that would result in a child being placed in an RMHTF.

BSS will be providing \$220 per day for its STAT homes. Of that, \$135 would be allocated to the provider to reimburse them for oversight and supervisory activities, training, data collection, and general services to support and retain the foster family. The remaining \$85/day would go directly to the STAT Home Family to cover treatment support (participation in meetings, training, and other treatment-oriented appointments) and room and board. This is an increase of \$54 per day above the current highest rate paid to traditional foster families (serving youth 13-21). The BSS rate is a flat rate regardless of the age of the child (versus the tiered rate structure for families in traditional foster care). DHHR is not paying for start-up or recruitment costs. Some CPAs may pay more than \$85/day but that is the minimum requirement.

DHHR reports that the nine CPAs providing STAT are in the recruitment phase, with one agency in the training phase. Some potential STAT Homes currently serve children and would become STAT Homes after the children are no longer in those placements. Specific data on the number of STAT Homes in the training phase and recruitment phase is not yet available. KEPRO will be monitoring the STAT Homes like they monitor the other tiers of foster care.

DHHR modified its CPA contract language to include a requirement that CPAs to notify BSS at least 24 hours in advance before any child can be moved between foster care homes. This policy change occurred as DHHR wanted to ensure that any moves were for the benefit of the child, and not the “system” or provider.

The SME acknowledges the work that the State has done to-date on outlining performance and outcome measures as well as the monthly reporting submission summary. DHHR has established

several metrics for the oversight of STAT Homes which are described in DHHR's Continuous Quality Improvement Plan. CPAs will be submitting monthly data with DHHR conducting monthly and quarterly reviews. DHHR is continuing to develop the specific process for those reviews, and who will participate. DHHR plans to engage families for feedback after programs are operational. They will be using surveys to obtain feedback. Additionally, the State has identified its intention to establish a future policy by which providers will not be able to move children between treatment foster care homes independently to manage their own contracted homes, but only in conjunction with BSS after review of what is in the best interests of the child.

Recommendations

1. DHHR has made progress in establishing a STAT Home model, providing a robust rate that differentiates this service from other foster care tiers, development of a SOP, defined quality metrics, and contractual language for the CPAs. The SME notes that there is no clear timeline for when STAT Homes will be available statewide. The current plan is to canvas current foster homes to see if they are interested. While this is a helpful starting point, the SME recommends that a STAT Home specific recruitment strategy needs to be developed. Jurisdictions have found that families interested in STAT Home like models may differ from families interested in long-term foster parents' roles. As STAT Homes lengths of stay are shorter, different families from those who select traditional foster care roles may be more amenable to that type of fostering role.
2. The SME notes efforts by DHHR to further differentiate youth eligible for STAT homes from youth who would be best served by its other tiers of foster care. The SME recommends that review of STAT AND Tiered Foster Care data will be necessary to ensure that the differentiation clearly addresses needs of youth and will inform any further modifications to STAT Homes or Tiered Foster Care levels. This analysis should include differences in demographics, presentation at time of placement, length of stay, achieved stability in the placement, and discharge/transition success crisis calls to CPAS and CMCR, psychiatric emergency department use and hospitalizations, residential interventions. As this data will not be available in the near term, the SME recommends that DHHR reflect in its quality plan when this type of review would be scheduled to occur.
3. The SME notes DHHR's plans to conduct surveys of families that provided STAT Home services in the future. The SME recommends obtaining youth feedback also. As noted in its June 2022 *STAT Home Update Powerpoint*, the SME notes that DHHR developed STAT Homes model with CPAS, CSED Waiver Providers, Aetna, DHHR staff, and foster families. The SME encourages the State to continue efforts too meaningfully engage families and youth in model refinement, and ongoing implementation. The SME continues to recommend that biological, kinship, and foster families *and youth* should share their experiences and serve on quality oversight and advisory bodies. The SME encourages the State to identify families with lived experience, youth or young adults currently or formerly involved with foster care, and TFC parents to provide input on the model and its implementation, both initially and on an ongoing basis. The SME encourages the State to compensate the families and youth financially for their participation.

4. As noted in prior SME reports, the State and DOJ are discussing differences in the interpretation of which children are required to be provided TFC services under the terms of the Agreement: whether it is all children in the target population or a subset who are in foster care. The SME has recommended that children, regardless of foster care status, can benefit from therapeutic foster care, especially as an alternative to other out-of-home placement settings. Allowing non-foster care children to be served in the STAT homes and TFC homes to prevent unnecessary entry into RMHTF. The SME understands that DHHR is focused on developing provider capacity for this service to meet the needs of foster care children and supports a revisiting of this Agreement requirement at a future date.

Reductions in Placement

Agreement Requirements: The Agreement requires the State to reduce the unnecessary use of residential mental health treatment facilities (RMHTFs) for children relative to the number of children living there on June 1, 2015. The expected goal by December 31, 2022, is a 25% reduction from the number of children living in residential mental health treatment facilities as of June 1, 2015, with additional benchmarks to be established and met over time.³

Activities

Per the terms of the Agreement, DHHR has committed to reducing the number of children receiving residential interventions. Table 14 below summarizes the June 2015 *Foster Care Placement Report* and calculates the 25% reduction that the State must achieve by December 31, 2022, and the additional reduction DHHR plans to reach by December 31, 2024.

TABLE 16: FOSTER CARE PLACEMENT REPORT, JUNE 2015⁴

Facility Type	Youth in an In-State Facility	Youth in an Out-of-State Facility	Total Youth in Any Residential Placement
Group Care	678	174	852
Psychiatric Facility (short-term)	63	86	149
Psychiatric Facility (long-term)	28	1	29
Parentally-placed in a psychiatric facility**			66 ⁵
2015 Totals	769	261	1096
Youth Receiving Residential Interventions With a 25% Reduction by December 31, 2022			822*
Youth Receiving Residential Interventions With a 35% Reduction by December 31, 2024⁶			712*

*Rounded to the nearest whole child.

³As discussed in the SME’s December report, the State has proposed reductions for additional years of the Agreement, including a 35% reduction compared to the 2015 date by 2024 and a commitment to propose further goals for reductions beyond the Agreement.

⁴<https://dhhr.wv.gov/bcf/Reports/Documents/2015%20June%20Legislative%20Foster%20Care%20Report.pdf>

⁵The number of children placed by their parents in psychiatric residential facilities as of June 1, 2015.

⁶As discussed in the SME’s third reported dated December 2020, the State has proposed reductions for additional years of the Agreement, including a 35% reduction compared to the 2015 date by 2024 and a commitment to propose further goals for reductions beyond the Agreement.

**Specifics for parentally-placed youth in in-state or out-of-state, or short- or long-term facilities in 2015 is not available.

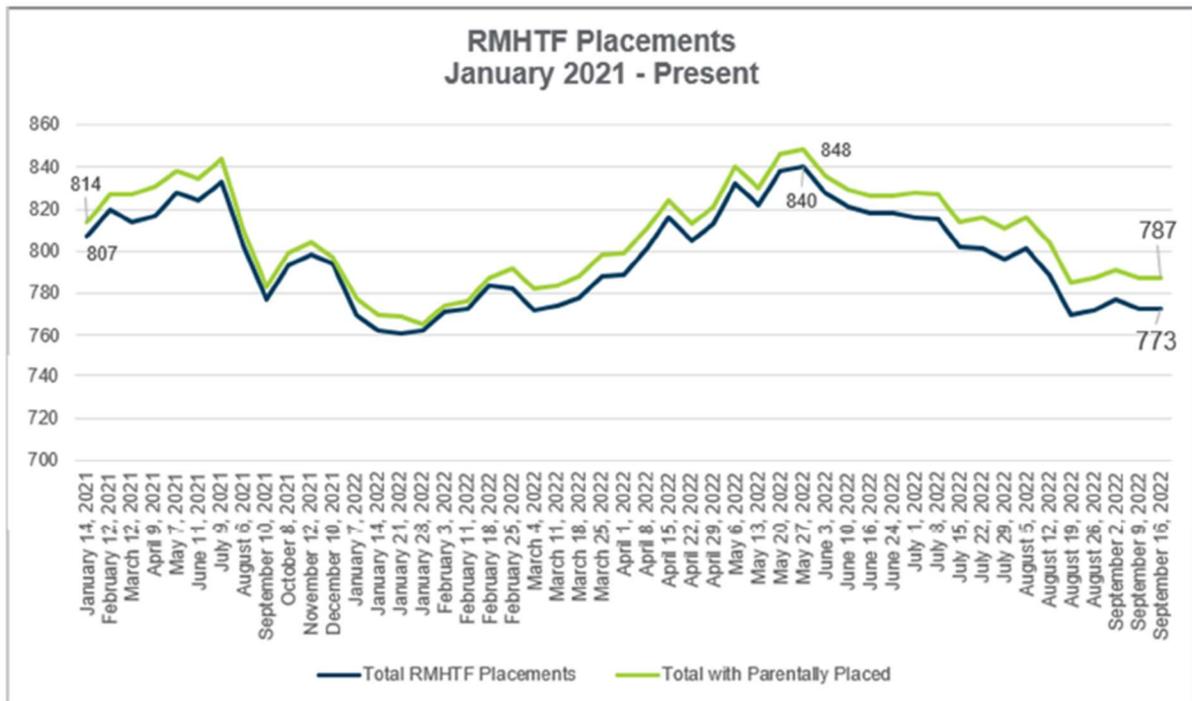
Residential data from the following sources was shared with the SME for this report:

1. Weekly RMHTF Placement Census
2. DHHR Internal QAPI Dashboard screenshots, September 12, 2022
3. Semi-Annual report, July 2022
4. Aetna Discharge Planning Report

The SME examined data specific to four factors: (1) total numbers of children served, (2) lengths of stay, (3) readmissions, and (4) discharge reasons.

Figure 2 below provides a weekly, point-in-time count of children remaining in any residential level of care at the end of each week.

FIGURE 1: RMHTF PLACEMENTS, JAN. 2021-SEPT. 2022



Data for the week of September 16, 2022, records a total of 787 children remaining in a placement, with 14 of that total parentally placed youth. This is below the target of 822 or fewer youth that DHHR must reach by December 31, 2022.

Using preliminary data from the September 12, Internal QAPI screenshots, most of the children newly admitted to residential placements in the most recent 12 months (Aug. 2021-Jul. 2022) were ages 13-17 (84%), with 12% of new admissions ages 9-12, 2% ages 5-8, and slightly more than 1% ages 18-20. Most of the youth enrolled were male (59%).

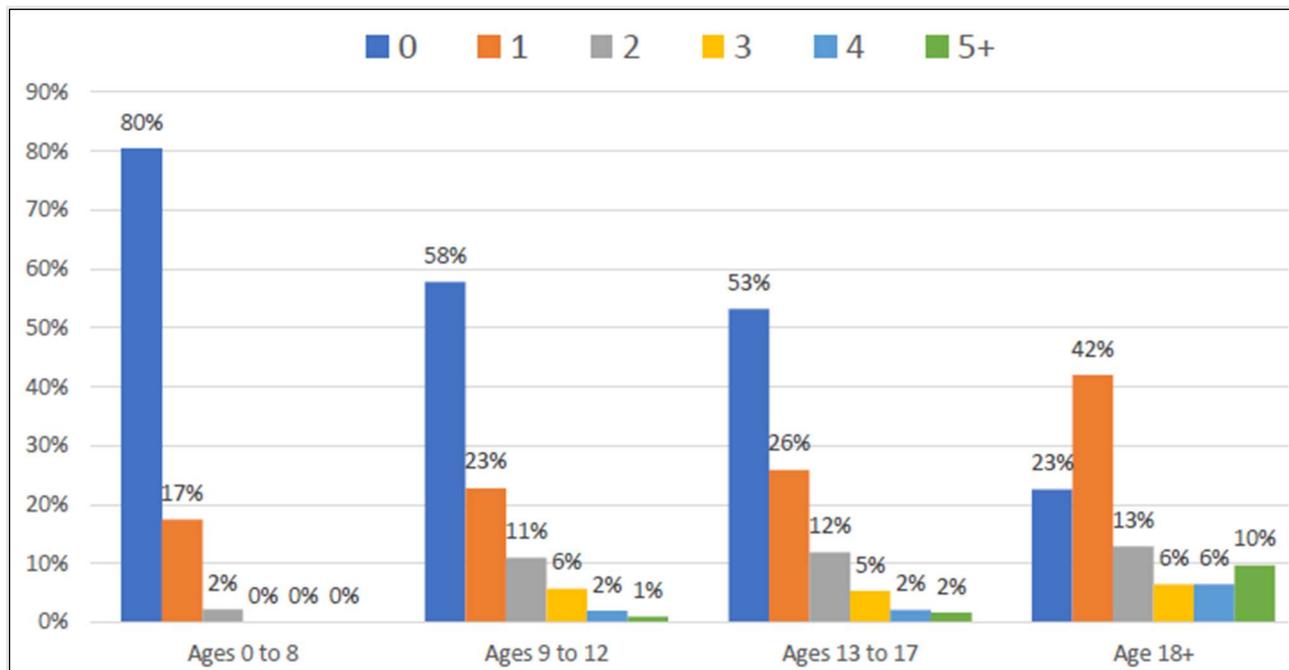
Length of stay was reported in both DHHR’s semi-annual, and in DHHRs internal working data sources shared with the SME. As available data increases, it will be necessary to clearly understand the different sources of information, the specific numerator and denominator used for each metric, and reflected timelines to move forward with understanding progress using consistent metrics.

TABLE 17: AVERAGE LENGTH OF STAY BY FACILITY TYPE, 2018-2021⁷

FACILITY TYPE	2018	2019	2020	2021
Group Residential	204	223	223	218
PRTF	276	257	275	267
Short Term Acute Psychiatric	35	40	34	37

While understanding overall lengths of stay across all residential services is an important indicator, there are usually differences between types of care that can inform system issues and action steps. In examining data by service type reported in the Semi-Annual report, July 2022, data indicates that ALOS had decreased for children in psychiatric residential treatment facilities from 2018 to 2021 but increased for children in group residential and short-term acute psychiatric hospitalization (figure 77, p. 100).

FIGURE 2: RMHTF ADMISSIONS BY AGE



DHHR’s July 2022 semi-annual report reflects that the statewide capacity for RMHTFs is sufficient to serve the total number of children requiring placements but that the individual needs of children may not always be able to be met in-state. DHHR is in the process of developing a service model for small, community-based group homes to serve populations of children who are more likely to be declined by in-state providers due to their needs. DHHR is also working to expand transitional living options and

⁷ See July 2022 semi-annual report, Figure 77, pg. 100.

services for older youth. In August 2022, DHHR issued a Call for Information (CFI) for *Innovations to Further Reduce the Use of Residential Mental Health Treatment*. The CFI sought innovative approaches to serve youth who do not meet clinical diagnostic criteria for RMHTF but are unable to be matched with a foster or adoptive home upon discharge. Responses were due Sept. 16, 2022 and extended to Sept. 30, 2022. Additionally, DHHR plans to release a Transitional Living Request for Application (RFA).

DHHR has indicated plans to develop a residential services provider manual in collaboration with Mountain Health Promise (MHP).

Consistent with Agreement requirement 52d, DHHR began piloting its Qualified Independent Assessment Process with Kepro and two BSS offices. This pilot will inform DHHR's final statewide assessment approach and overall timeline. DHHR plans to include information about this pilot in its next semi-annual report.

Since November 2021, MHP has been reporting CAFAS scores and other data to DHHR monthly, beginning with CAFAS scores under 90 for children in residential placements.

DHHR has continued to work on the Decision Support Model and its integration with the CANS. Initial analysis indicated that it aligned with the Qualified Independent Assessment. Activity related to the Assessment Pathway includes development of an Out-of-State Placement Review SOP draft and face sheet, an Intensity of Intervention Form, a 30-Day Reauthorization/Reevaluation process, and Transition Process Recommendations. In July 2022, DHHR sent a letter to the providers regarding the implementation of the 30-day reauthorization process, with a letter on Sept. 14, 2022, informing them that the new protocol would be effective Oct. 1, 2022.

The State has engaged Casey Family Programs and Chapin Hall in ongoing technical assistance to support practice-based reforms with its residential providers. These regular meetings with residential providers have led to the identification of several collaboration areas with providers to improve policies, infrastructure, and quality practice.

Recommendations

1. The SME recommends that DHHR continue its efforts to redirect children away from residential placement through continuing efforts to work with judges and courts, specifically continuing education efforts specific to judges and courts regarding available HCBS services. These education efforts must be a multi-layered approach that includes sharing local data with judges with a comparison to statewide data, meetings between judges and HCBS providers in their area to discuss how these HCBS services can meet the needs of youth that would otherwise be referred to residential, discussions with youth and families with lived experience in HCBS, including how such services supported them in remaining in their community.
2. The SME recommends that DHHR continue its efforts with its own BSS caseworker staff to redirect children from residential and to HCBS.

3. The SME recommends that DHHR continue monitoring weekly census data to support compliance with the Agreement requirement to sustain a reduction at or below 822 youth residing in residential care per month.
4. The SME commends the State for its work on collecting and analyzing residential placement data. There has been a significant improvement in the quantity and specificity of data available. DHHR has included metrics in its Dashboard that will support its' understanding of the needs of youth and provide actionable information to improve care. As DHHR prepares for compliance review of residential services scheduled to occur Spring 2023, it will be important for DHHR, DOJ, and the SME to have a shared understanding of the use and implications of different metrics. As noted, depending on the data source, metrics vary in their definition, time periods, and data source with average length of stay, and total counts of utilizers, varying across the different metrics. These differences are to be expected in any system.
5. The September 12, 2022 point-in-time figures show that DHHR achieved a reduction in residential below the required target of 822 three months earlier than required. While maintaining enrollment below 822 is required as of December 31, 2022, and continued reductions are needed beyond that figure in subsequent years, it is also important to anticipate that change may not continue in a methodical, linear fashion. A nonlinear reduction in residential use may occur as DHHR change to its community-based services and as its delivery of residential services matures. In support of further reductions, the SME recommends DHHR address:
 - a. Readmissions. The SME recommends that the State conduct an analysis of children with readmissions to identify the factors that precipitated or likely led to readmission.
 - b. Details regarding children that cannot be discharged and the reasons why, particularly youth who lack a discharge plan as the Chapter 531 Psychiatric Residential Treatment Facility Services manual requires discharge planning to begin at intake
 - c. The number of children with CAFAS scores 80 or below and the discharge plan for each youth.
 - d. Differences in children that are referred for out-of-state residential services compared to the service needs of youth served in-state (e.g., demographics, county of residence, diagnosis, involvement with juvenile justice, previous history of aggression or elopement, etc.). These groups of children have significantly different lengths of stay but it is not yet clear if the two groups differ in complexity of need, have significantly different CANS scores, or if physical distance which increases the challenges in discharge and transition planning is the sole factor for different ALOS.
6. Implement quality improvement efforts to improve discharges and address barriers that prevent timely discharge with particular focus on three areas:
 - a. Planning to resolve the currently unreported race/ethnicity data and "reason cannot be served in the community," which were not included in 205 records, or

almost two-thirds of records. The SME understands that race/ethnicity data is reported in FACTS and the data store will pull from FACTS in 2023. Additionally, the SME understands that data on why the individual cannot be served in the community is not currently collected but the State intends it to be included in future QI processes.

- b. For available discharge data, analyze categories such as discharged to a lesser level of care to report on whether these children remained in residential treatment.
 - c. CAFAS scores of less than 90 and greater than 90.
7. The SME recommends that the State continue to monitor LOS to ensure that it does not increase, and to understand factors that aid its' decrease, and report trends specific to which system sought residential placement for the youth, variations by regional/county, service type, and clinical and social needs of the youth. An increasing LOS suggests that there are barriers related to transition, discharge planning, and implementation, as well as a possible incongruence between the services identified to meet the child's needs and the services provided. Factors supporting a decrease will aid DHHR to identify activities, policies, and processes that can be scaled across the state. Additionally, it will be important to know how LOS is affected by the large numbers of children that are in residential but could be otherwise discharged or those for whom the data records "no viable discharge plan."
8. The SME recommends the State determine why children do not have discharge plans and implement a corrective action plan with providers and DHHR personnel to ensure all children have individualized and appropriate discharge plans no later than Feb. 1, 2023. The SME recommends that the State undertake a qualitative review of youth in RMHTFs without appropriate discharge plans. Under the [current RMHTF manual](#), which DHHR is in the process of updating, treatment planning must include activities "intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time." In addition, the treatment plan must include, "at a minimum...[a]n individualized discharge plan that includes discharge criteria, indicating specific goals to be met, and an estimated discharge target date." Given the requirements in Chapter 531, no child should be without a discharge plan and there should never be an instance where there is uncertainty about whether a discharge plan exists. As part of this detailed review, we recommend the State use the process to understand:
 - a. The characteristics of youth who are admitted to RMHTF with low CAFAS/PECFAS scores or other data that suggests low acuity;
 - b. Youth with multiple admissions to understand their progress within each treatment episode and aftercare plan required by Chapter 531. What common characteristics exist among these youth (age, race/ethnicity, custody status, county of residence, DJS involvement, school suspension or expulsion, etc.)? What factors and functional improvements are associated with discharge among this group? Did these youth experience delays in discharge because aftercare planning services or placements were not readily available (e.g., no home- and community-based providers in the county of residence, wait lists for services, lack of foster parent or kinship care, housing for older youth, etc.); and

- c. Any system level factors impacting the lack of discharge plans such as regional/county variations, demographics of the youth, residential level of care or provider variations, in-state or out of state variations, strength or weakness of residential internal accountability and oversight mechanism, etc.
9. The SME recommends the State build upon the excellent work it has done in analyzing data related to youth with a CAFAS/PECFAS score less than 90. The SME recommends the State to engage in similar activities for youth with a score of 90 or greater.
10. The SME commends DHHR on its policies requiring the CANS to be completed every 30 days and to require all children in residential to be referred to the Assessment Pathway at the time of admission. The SME acknowledges the continued Assessment Pathway work and recommends:
 - a. Tracking the timeliness of the 30-day reauthorization review forms and associated decisions, as well as any actions to adjust the timeline, if necessary, to ensure that documents are submitted in a timely manner while setting reasonable expectations; and
 - b. Monitoring and, if needed, guidance on the reauthorization/revaluation process when a youth is nearing discharge. The protocol suggests that the reauthorization is not required but it is unclear if “nearing discharge” been defined or if the State or its partners are tracking when the youth is discharged.
11. As discussed elsewhere, the SME acknowledges the work the State has done in developing and implementing a Decision Support Tool. The SME observes that there is a risk of underutilizing Treatment Foster Care and encourage the State track utilization. Additionally, the SME noted that the Level 4 of the Decision Support Tool requires youth to be 12 years old and not 13, which would be consistent with the Family First Prevention Services Act. Using a different age than FFPSA could lead to confusion across the workforce, may result in services not being eligible for federal reimbursement, and does not align with typical practice.
12. The State has made progress on its Intensity of Intervention Form. The SME recommends that the State define the phrase “not cooperative with the Court’s requests,” as it is highly subjective, and integrate number of prior placements into the risk factors (such as those listed on page 2).
13. The SME appreciates the opportunity to review the Out-of-State Placement Review SOP Draft document and recommends that it be revised to include:
 - a. Adding the steps in the OOS Placement Review SOP Draft into the flowchart to ensure the detail is provided;
 - b. Explicitly stating the role of the child and family and their input, as well as the care team’s, for the OOS Placement Review;
 - c. Clarifying why conduct disorder results in an automatic denial on the OOS Placement Review; and
 - d. Defining the child welfare consultant position be defined with more detail provided in the SOP.

14. The SME recommends that the Transition Process Recommendations be revised to:
 - a. Differentiate between “appointments scheduled” and “referrals made” to ensure that the youth receive a warm handoff and as much support as possible, including transportation, as they transition;
 - b. Ensure consistency and alignment with the 30-day Reauthorization process, which informed providers it was their responsibility to refer youth to the CSED Waiver;
 - c. Be more precise with responsibilities to ensure that accountability is not diffuse (e.g., Educational Policy);
 - d. Clarify the home visit requirements and whether the provider is expected to assess for safety and what happens if someone identifies a safety concern; and
 - e. Clarify which activities are required only when the youth is discharging from foster care as well as from the residential setting.

15. DHHR provide an update on the process, and learnings from the Commissioner level sign-off policy and procedure enacted by BSS for out-of-state placements, particularly as it relates to the needs of those youth, and DHHR’s efforts with providers to find an -in-state resource before out of state options were pursued.

Outreach and Education

Agreement Requirements: The Agreement requires the State to (1) conduct outreach to and training for physicians who serve children who are Medicaid-eligible on the use of the screening tools; (2) develop outreach tools for medical professionals who treat Medicaid-eligible children; (3) develop an outreach and education plan for stakeholders in the State of West Virginia on the importance of the stated reforms prescribed in the Agreement; and (4) provide timely, accurate information to families and children regarding the in-home and community-based services that are available in their communities.

Activities

Since the last SME report in April 2022, the State has engaged in multiple **meetings with partners and stakeholders** regarding several of the in-home and community-based services. These meetings include a Pediatric Mental Health Outreach and Communication Focus Group,⁸ a Primary Care Provider Outreach Workgroup,⁹ and a CSED Waiver Policy Clarification Conference Call.¹⁰ The State also hosted two Child Welfare Collaborative meetings during this report period in March and August of 2022.¹¹ In addition to the aforementioned meetings for which the State provided specific reports or documents related to the outreach, the State has also developed an **Outreach Tracker Inventory tool** to log and monitor outreach and education activities related to Agreement services. In December 2021, the workgroup developed a list of draft data inputs that will be used in the tracker.¹²

⁸ See “20220825_Notes_Pediatric_Outreach_Group” document.

⁹ See “PCP_Outreach_Workgroup_Notes” document.

¹⁰ See “CSED Waiver Policy Clarification Conference Call Agenda for July 13, 2022” document.

¹¹ Note: As of the August 2022 meeting, the State has renamed these meetings “Kids Thrive Collaborative” meetings, keeping with the changes to the website and other related rebranding.

¹² See “Edited_Outreach Tracker Data Inputs draft” document.

This data input work is aligned with the general QAPI work of the agreement and is being incorporated into practice the State indicates that starting in October 2022, DHHR will begin reviewing the content of the Outreach Tracker along with the Office of Quality Assurance to define specific indicators for the next semiannual report. Guidance on ongoing use of the Outreach Tracker is included in a standard operating procedure (see below).

The State has indicated, via its Outreach Tracker, outreach to judges, including in-person outreach at a statewide judicial conference in May 2022.

The State also made **significant changes to its website**, moving from the West Virginia Child Welfare Collaborative (“childwelfare.wv.gov”) to the West Virginia Kids Thrive Collaborative (“kidsthive.wv.gov”). In the SME’s opinion, the updated website is more user friendly and easier to navigate. For example, all the SME reports are located in the same place on the website. The technical issues mentioned in earlier reports appear to have been resolved. The SME also notes that processes for maintaining website content, removing outdated content, adding new content, and performing technical maintenance are included in the new standard operating procedure regarding external outreach.¹³ In addition, the “Kids Thrive” rebranding is accessible and welcoming for any who may have been discouraged or confused by the previous Child Welfare focus. These website changes are consistent with past SME recommendations to leverage the website as a key tool to provide information to stakeholders.

One significant development during the report period was the development and hosting of **“Resource Rundown”** sessions. These sessions were offered weekly starting August 23, 2022 and are ongoing as of this report. A recorded version of the presentation has been made available on the Kids Thrive website. As of August 16, 2022, DHHR had published four follow up questions and responses in an FAQ document available on the Kids Thrive website. The SME supports the plans to develop and host another version of the Resource Rundown specifically targeted towards youth.

DHHR created a document outlining the **standard operating procedures** for external communications regarding HCBS;¹⁴ the SOP covers topics such as maintenance of the Kids Thrive Collaborative website, messages for different audiences regarding HCBS access, and the process for tracking and monitoring external outreach. The final SOP is inclusive of the content shared for the draft SOP for the April 2022 SME report, but also includes new content, which appears to be a previous SME recommendation, the State provided an email¹⁵ showing that DHHR has raised the issue of adding a specific **statement to the annual EPSDT postcard** that a mental health screen is included as part of the HealthCheck exam. The SME looks forward to seeing the final language for the postcard.

The State shared its **Outreach Prioritization Map** along with the methodology for the map.

The SME recommends that the MCO and DHHR strategy be coordinated. MCOs are important agents to this work; but their role is prescribed and DHHR’s efforts can reach a broader audience.

¹³ See “Standard Operating Procedures: Outreach to External Audiences Regarding the Pathway to Children’s Mental Health Services” document.

¹⁴ See “Standard Operating Procedures: Outreach to External Audiences Regarding the Pathway to Children’s Mental Health Services” document.

¹⁵ See “BMS Biweekly MCO Notes Section – EPSDT inclusion postcard 20220907” document.

The State has initiated conversations with Aetna about adding clarifying language to the EPSDT postcard about the mental health screening; this revision appears possible. As noted in the Outreach Tracker, a representative from Aetna also presented on a CSED Quality Improvement Advisory (QIA) Council call about the pathway and criteria for using CSED services.

The State has indicated that a meeting with the **Department of Homeland Security and the Department of Education** is planned for fall 2022 to discuss collaboration on engagement efforts. The SME looks forward to receiving an update from this meeting and the resulting plans for collaboration moving forward.

The State acknowledges receipt of a revised version of the **Youth and Family-level Evaluation Report** prepared by West Virginia University. These materials included both a full-length evaluation report and a shorter, more easily digestible summary document. The initial version of the full report was created in July 2022 and the revised version was issued on September 15, 2022, just before the deadline to submit materials for this report. The SME will review the contents of the evaluation report in early November and will share its feedback with the State.

Recommendations

1. The SME continues to encourage outreach and engagement strategies that allow for two-way engagement with youth and families. For example, the creation of the Resource Rundown has been a major development during this reporting period. The time and planning that went into the Rundown is evident in the webinar hosting, the available recording, and the written responses to questions received during or after the webinar. The content is clear and the messaging is obviously well thought out (e.g., clarifying several times that calling for resources does not mean the child will go into the child welfare system). The Resource Rundowns are didactic rather than interactive and are not a venue for active dialogue (as noted in qualitative feedback in the family Resource Rundown survey). DHHR has communicated to the SME that it understands two-way communication is needed but that it wants to keep the written Q & A approach for now to ensure consistent information is communicated and that meeting issues stay on point. The SME nonetheless encourages DHHR to hold interactive discussions with youth and families, whether as a part of the Resource Rundowns or through another medium. The SME also encourages the State to consider other adaptations/additions to capitalize on the time and effort invested in the Resource Rundowns, such as offering sessions during evening hours¹⁶ and/or publishing a transcript of the recorded Resource Rundown that is searchable and 508-compliant. As noted above, the SME strongly supports the plan to create a complementary version of the Resource Rundown specifically designed for a youth audience.
2. The results from the Resource Rundown survey indicate a bifurcation between attendees who identify as family members and professionals (i.e., providers and others “interested in obtaining information for families with whom [they] interact with”). The State has verbally indicated that it will review the survey results at a future meeting and consider its response.

¹⁶ The State has noted that a recording of the Resource Rundown is available for people who cannot join “live” during one of the Tuesday afternoon webinars.

The SME encourages the State to carefully review the survey results (including qualitative feedback) and consider whether there are additional methods to solicit feedback from these two groups of attendees.

3. In response to a SME recommendation from the April 2022 report, the State has indicated that it plans to finalize the the 2020-2024 Outreach and Education Plan before the conclusion of the next reporting cycle. The SME welcomes these updates as we believe that regular updates to this plan are an important component of the Agreement.
4. As we move closer to the compliance assessment of the outreach and education component of the agreement, the SME encourages the State to consider which indicators will best reflect the results of DHHR and its partners' outreach efforts. This would likely include both process measures (e.g., how many attendees were at X outreach event, how many postcards with X information were sent) and outcome measures (e.g., are families/youth more aware of available services, do families/youth understand how to access services). The outreach tracker appears to be an important tool to track the former type of measures; the State should ensure it has also thought through how to track the latter type.
5. As noted above, the State has done excellent work during this report period to improve the website for the Collaborative and to implement procedures to keep content up-to-date and to eliminate technical issues. Now that the transition to the new website has occurred, the SME encourages the State to use its outlined procedures to add more content to the Kids Thrive website. For example, the "How Do I" tab on the home page is an inviting. However, the tab only contains three questions and their responses. The SME encourages the State to ensure that a broad range of education resources are available through the Kids Thrive website in addition to its statements directing people to the Children's Crisis and Referral Line. For example, the former Child Welfare Collaborative site included a "Services" page with a brief description of each agreement service. While the Resource Rundown contains similar information about the available HCBSs, a new user might not necessarily know that the Resource Rundown is the place to find that and would still need to watch through the video to find out, even if they were just looking for information about one service. The SME encourages DHHR to further develop the information available on the Kids Thrive website to make the most of the website as an education tool.
6. In preparation for compliance assessment of outreach and education efforts in the fall 2023 report, the SME encourages the State to continue to clarify which of its outreach and education efforts are specific to the services outlined in the Agreement and which are part of DHHR's general function to educate the public and conduct outreach. The "purpose of outreach" field of the Outreach Tracker is an excellent development that can support the State in distinguishing which efforts are specifically related to Agreement services.
7. The SME recommends that DHHR review its communication plans to ensure they align with MCO noticing requirements to ensure coordinated reach. Given the contractual expectations on MCOs to provide information and notice of EPSDT requirements, their role, activities, and successes are not reflected in the materials submitted to the SME. As such, it appears that

these activities are not yet fully incorporated into DHHR’s overall outreach and education strategy.

8. The SME continues to encourage the State to consider how it can maximize the value of the Kids Thrive quarterly meetings. Specifically, the quarterly meetings may offer an opportunity for two-way communication with youth and families.
9. The SME requests an update on the contracted work with the WVU Office of Health Affairs to “implement a public education initiative aimed to raise awareness of HCBS.”¹⁷ Specifically, the State shared a contract for “Phase 1” with a project period from November 2021 to March 2022. The SME requests an update on the outcome of this Phase 1 work, as well as information about if/when a Phase 2 may be implemented and what that phase may encompass.

Conclusion

DHHR has made considerable progress on Agreement requirements including implementing infrastructure, developing data metrics and reporting capabilities, training providers and DHHR personnel. Notably, DHHR has reduced its weekly residential census below the 25% reduction required by December 31st of this year. DHHR will need to continue its efforts that are already underway to work with providers, the court community, and its own DHHR personnel to sustain this number and plan for future reductions, including improving discharge planning and directing children and youth to home- and community-based services.

Given DHHR’s considerable efforts to improve the availability, accuracy, and timeliness of its data, as well as its reporting and analysis capacity, trends are emerging that indicate strengths, successes, and opportunities for improvement. As DHHR continues to build its data culture, rapid cycle improvement efforts that address identified challenges, enhance quality care and timeliness, are essential.

Just as DHHR had prioritized its resources to increase its focus on residential during the past year, it is important for the Department to continue expanding home- and community-based services, including provider capacity. Drawing parallels to DHHR’s cross-system effort to address use of residential, a cross-system effort to address the concomitant factors affecting workforce development, education, training and coaching, recruitment, and retention is needed. In addition to continuing its efforts to broaden the scope of existing providers and providing ARPA funding and rate increases, additional workforce strategies discussed in the report will need to be considered for DHHR to provide sufficient statewide, high-quality, timely services to meet the needs children, youth, and their families.

¹⁷ See “Medicaid Home and Community-Based Services Public Education and Outreach – Phase 1” contract, provided to the SME in preparation for the April 2022 report.

Appendices

Appendix A — Reviewed Documents Received During the Report Period

The list below reflects documents received during the current reporting period only.

ACT

- ACT EPH Startup Collaboration rev 20220309
- ACT Team 2022 Updates.xlsx
- KEPRO September 2022.docx
- Revised ACT Scoring Tool Kepro_draft_20220828.docx
- SME ACT Meeting.pdf
- WVDHHR SME ACT Presentation September 2022.pdf

Assessment

- 20220922 DHHR Assessment SME Presentation (1) (2).pptx
- Assessment Pathway August 2022 QC Review SF Comments for follow-up .docx
- Assessment Pathway August 2022 QC Review.docx
- Assessment Pathway Phase 1 Desk Guide rev 20220820.docx
- BSS Pathway Implementation revised 20220829.docx
- Bureau of Juvenile Services Protocol for MAYSI-II and CSED Pathway (Draft).pdf
- CANS Data Plan-Projected Sept 2022.docx
- CPS Ongoing Assessment 10-2021 (1).docx
- DECISION SUPPORT MODEL_WV CANS_LOC_FINAL_rev20220912.docx
- DHHR Pathway Series 20220523.pdf
- FAST, Ongoing Assessment, and Case Planning Implementation Plan.docx
- Intensity of Intervention Assessment Form FINAL 20220727 rev20220912 (1).pdf
- Kepro Qualified Independent Assessment Results and Recommendations Report.docx"
- Project Plan and module specifications for assessing service capacity and workforce need 20220908.xlsx
- Referral for Qualified Independent Assessment SOP Final 2022.09.15.docx
- SME_Assessment_Recommendations.pdf
- WVDHHR SME Assessment Presentation.pdf
- WVDHHR SOP - External CMHS Outreach.pdf

BSS

- Concord University Behavior Support Services Training Plan.docx
- Concord's PBS Training.msg
- PBS Brochure-CU.pdf
- SME PBS Presentation.pdf
- WVDHHR SME BSS Presentation September 2022.pdf

CMCR

- CCRL Referral Guidance 3-15-22.docx
- CCRL SOW FirstChoice 2022 - G220699 Grant Agreement.pdf

- Childrens Crisis and Referral Line Internal CQI Review Report.docx
- FCS Call Center Policies and Procedures.docx
- FINAL 9.8.2022 Childrens Crisis and Referral Line Quality Assurance SOP .docx
- WVDHHR SME CMCRS Presentation.pdf

CSED

- 20220321_CSED_Public_Comment_Log_rg 4.4.22_sky.pdf
- Approved CSEDW Program Overview for July 1 Amendment.pptx
- Attendance at DPS Probation Training 2022.pdf
- Attendance for technical assistance on CSED Waiver Charts.xlsx
- CSEDW DOJ SME Provider Detail for Providers Chosen for Services March 1 2020 thru August 31 2022.xlsx
- Handout 5 CSED Waiver Overview.pdf
- In Home Case Management 4.12.22 Excerpts.docx
- Kepro Qualified Independent Assessment Results and Recommendations Report.docx"
- SED Waiver Initial Training 2022 .pdf
- Training Doc Kepro.docx
- WVDHHR SME CSED Wraparound Presentation September 2022 .pdf

Outreach and Education

- 20220825_Notes_Pediatric_Outreach_Group.pdf
- BMS Biweekly MCO Notes Section - EPSDT inclusion postcard 20220907.pdf
- Child Welfare Collaborative 3-30-22.pdf
- KTC Email - Meeting Agenda 033022.pdf
- KTC Email - Meeting Notes 080922 - Save the Date 110122.pdf"
- O&E_7_14_22.docx"
- Outreach Prioritization Map_Sept 1_Final.pptx
- Outreach Tracker Inventory 20220916.xlsx
- Outreach Tracker Materials.zip
- PCP_Outreach_Workgroup_Notes.pdf
- Resource Rundown Auto-Reminder Email.pdf
- Resource Rundown FAQ.pdf
- Resource Rundown Follow-up Email Attendees.pdf
- Resource Rundown Image.png
- Resource Rundown Launch – KTC Email Notice 20220816.pdf
- Resource Rundown Launch Press Release 20220823.pdf
- Resource Rundown Performance Report.xlsx
- Resource Rundown Proposal Approved.docx
- Resource Rundown Q&A Follow-up Email.pdf
- Resource Rundown Survey Results (Families) 20220909.pdf
- Resource Rundown Survey Results 20220909.pdf
- Resource Rundown Survey.pdf
- Resource Rundown webinar slide deck.pdf

- SME Outreach and Education Presentation Sept 2022.pdf
- WVDHHR SOP - External CMHS Outreach.pdf
- WVU Youth and Caregiver Level Evaluation Report FINAL 20220915.pdf
- WVU Youth and Caregiver Level Evaluation Summary Report 20220915.pdf

QAPI

- 20220506 Revised At-Risk target population.docx
- 20220712_QAPI Update_SME_Final.pdf
- 20220912_QAPI Update for SME.ppt
- 20220914_CQI_Plan_Final with Response to SME Comments.docx
- 20220914_Semiannual Report and QAPI Update for DOJ_Final.pdf
- 20220914_Semiannual Report and QAPI Update for DOJ_Final.ppt
- August 31 Quality Committee Review Data Slides 08312022.ppt
- CANS Data Plan-Projected Sept 2022.docx
- CMHE_DEL_CommunityLevelSummaryReport_20220728 (003).pdf
- DHHR Status for Addressing Paragraphs 48-50 Requirements.docx
- July 2022 DHHR Semi-Annual Report_FINAL.pdf"
- Key Performance Indicator Tables (Working Document).docx
- Projected QAPI-CQI Data Store Roadmap 202209 Final.xlsx
- QAPI Dashboard and Database Technical Documents.zip
- WVUEvaluation_OrgFacSurvey_DataTables.xlsx
- WVUEvaluation_OrgFacSurvey_Survey.pdf
- WVUEvaluation_ProviderSurvey_DataTables.xlsx
- WVUEvaluation_ProviderSurvey_Survey.pdf
- WVUEvaluation_SystemCommunity_Baseline_REVISED (1).pdf

Residential

- Aetna Discharge Planning Report_20220907.docx
- DECISION SUPPORT MODEL_WV CANS_LOC_FINAL_rev20220912.docx
- Intensity of Intervention Assessment Form FINAL 20220727 rev20220912.pdf"
- OOS Placement Process SOP DRAFT (v1)20220804.docx
- OUT OF STATE FACESHEET_Revised 20220714.docm
- Provider Letter 30-Day Reauthorization Reevaluation.pdf
- Provider Process - Pathway and 30 Day Reassessment.pdf
- R3 SME Recommendations.pdf
- Residential Placement 30-Day Reauthorization Review Process.docx
- Residential Placement graph through September 9_2022.docx
- Transition Process Recommendations.pdf
- WVDHHR Call for Information Aug-Sept 2022 BRIDGE MODEL.pdf
- WVDHHR SME R3 Presentation September 2022.pdf"
- WVDHHR SME R3 Presentation.pdf
- WVDHHR Weekly Update 20220916.pdf

Screening

- 20220922 Childrens_Mental_Health_Screening_Update (1).pptx
- Addendum - BSS Pathway Implementation FAQ (4.01.2022).docx
- BSS Pathway Implementation revised 20220829.docx
- Bureau of Juvenile Services Protocol for MAYSI-II and CSED Pathway (Draft).pdf
- Bureau of Juvenile Services Screening Report.docx
- CPS Ongoing Assessment 10-2021 (1).docx
- DHHR Pathway Series 20220523.pdf
- DOJ 2021 Report - Mental Health Screening in EPSDT Annual Retrospective Analysis of Med Records Linked to Administrative Claims 1.docx
- FAST, Ongoing Assessment, and Case Planning Implementation Plan.docx
- HealthCheck PCP Referral Survey - Sept 2022.pdf
- HealthCheck PCP Training Slide Deck – Sept 2022.pdf
- Probation Service Screening Report.docx
- Screening Priorities.docx
- SME_Screening_Recommendations.pdf
- WVDHHR SME Screening Presentation.pdf

TFC

- SME STAT Home Meeting 6-22-2022.pdf
- Stabilization and Treatment Home SOP - Final June 2022.pdf
- STAT Home Addendum BETHANY CHRISTIAN SERVICES SIGNED 7.26.22.pdf
- STAT Home Reporting Summary.pdf

Workforce

- 20220718_Workforce Updates.pdf
- Project Plan and module specifications for assessing service capacity and workforce need 20220908.xlsx
- TSW status report May-August 2022.docx
- WF Capacity Deployed Across BBH CSED and SAH June 2022 with replaced ID.xlsx
- WVDHHR SME Workforce Presentation September 2022 (1).ppt
- WVU ARPA Projects Update 20220908.docx

Wraparound

- DART Training timeline-status update 08-24-2022.docx"
- DECISION SUPPORT MODEL_WV CANS_LOC_FINAL_rev20220912 (1).docx
- Marshall University DART Fidelity Training.pptx
- Marshall University DART Training Timeline.docx
- NWIC West Virginia Wraparound Training Calendar.pdf
- NWIC West Virginia Wraparound Training Participant Manual.pdf
- NWIC West Virginia Wraparound Workforce Development Plan.pdf
- POC training handout-compressed 9-29-2022 to SME.pdf
- SME Wrap CSEDW Presentation.pdf
- Update to Wraparound Manual.msg

- West Virginia Wraparound Manual Final version 2022.09.12.docx
- West Virginia Wraparound Manual Final version updated 2022.09.29.docx
- WF Capacity Deployed Across BBH CSED and SAH June 2022 with replaced ID.xlsx
- Wraparound Fidelity Update 08-24-2022.docx
- Wraparound Fidelity Update 09-13-2022.docx
- WV Wraparound Individual Plan of Care Desk Guide 10 1 22 Final.docx
- WVDHHR SME CSED Wraparound Presentation September 2022 .pdf

Appendix B — Contacts with West Virginia and the Department of Justice

Meetings	Dates
Department of Justice	April 11, 2022; April 27, 2022; May 6, 2022; June 17, 2022; June 22, 2022; July 13, 2022; July 29, 2022; August 10 th , 2022; September 14 th , 2022; September 28 th , 2022
DHHR	April 6, 2022
Child Welfare Collaborative	August 9, 2022
Calls with C. Chapman	April 1, 2022; April 18, 2022; April 22, 2022; May 2, 2022; May 20, 2022; May 27, 2022; June 2, 2022; June 17, 2022; June 24, 2022; July 8, 2022; July 29, 2022; August 5, 2022; August 12, 2022; August 19, 2022; September 9, 2022; September 30, 2022
WVU	July 13, 2022
CMCR	July 14, 2022; September 12, 2022
Wraparound	July 12, 2022; September 21, 2022
TFC	May 24, 2022; June 22, 2022; September 20, 2022
Screening	July 15, 2022; September 21, 2022
Assessment	July 14, 2022; September 21, 2022
PBS	July 12, 2022; September 20, 2022
Outreach and Education	July 14, 2022; September 19, 2022
QAPI	July 12, 2022; September 12, 2022
Residential (R3)	July 15, 2022; September 21, 2022
ACT	July 12, 2022; September 20, 2022
Workforce	July 18, 2022; September 21, 2022
CSED Waiver	May 24, 2022
Target Population	June 28, 2022; September 20, 2022

Appendix C — SME Compliance Rating Criteria

CATEGORY	CRITERIA
Substantial Compliance	<p>Has undertaken and completed the requirements of the paragraph; no further activity needed OR</p> <p>Has undertaken and completed the requirements of the paragraph--met with updates continuing to occur.</p>
Partial Compliance	<p>Compliance has been achieved on some of the components of the assessed paragraph or section of the agreement, but significant work remains;</p> <p>Has developed deliverables that indicate the state is actively addressing the requirements of the paragraph;</p> <p>Has provided data that indicates the State is actively addressing the requirements of the paragraph;</p> <p>Has implemented activity and has yet to validate effectiveness;</p> <p>Has implemented activity but has not developed procedures to assess the effectiveness of the service or has not taken adequate measures to ensure its sustainability after the agreement terminates;</p> <p>Has begun activities but not completed implementation activities.</p>
Non-Compliance	<p>Non-compliance indicates that most or all of the components of the assessed paragraph or section of the agreement have not been met;</p> <p>Has made little or no progress to meet the targets set forth in the Agreement, Implementation Plan or other plans;</p> <p>Has done no work to meet the date as set forth in the paragraph of the Agreement.</p> <p>Has not provided data or access to staff so that the Subject Matter Expert may properly assess compliance.</p>
Not Rated	<p>Not Rated indicates a paragraph or section of the agreement where the parties have agreed that the Subject Matter Expert shall not rate the State's compliance during the assessment period.</p>
<p>NOTE: All criteria are applied specific to the time period reviewed. For example, a rating of partial compliance in one report period would not necessarily continue to be rated as partially compliant if there is no continued evidence of progress. A rating of substantial compliance in one report period would not continue to be rated as substantially compliant if achievements were not maintained.</p>	

SUPPORTING DOCUMENTATION

The SME will rely on written information, and data from the Quality Assurance and Performance Improvement (QAPI) System and the quality sample reviews of children, provided by the State to arrive at its evaluation. Deriving compliance from written document has limitations as even the best-intentioned policies do not succeed or fail on their own merits; their progress is dependent upon the processes of implementation. Noting this limitation, the SME's determination of substantial compliance will rely on data from the QAPI and the quality sample reviews of children, and implementation of the State's continuous quality improvement plan in which the State implements changes to policies, procedures, practices, regulations and other relevant State guidance and activities based on trends in QAPI data.

Information reviewed will include, but is not limited to:

1. Standard Operating Procedures and Contracts – contract requirements, policies and related documents such as service descriptions; admissions, continuing stay, medical necessity, and discharge criteria; provider bulletins, communications with providers, manuals, and transmittals; billing and reporting requirements and manuals; staffing requirements; and documentation requirements, meetings with providers and stakeholders.
2. Training – initial and continuing training requirements for services, supports, and staffing; training curricula, including seat-time and competency-based requirements; training specificity (i.e., is the training sufficient to deliver to the service in a manner that is likely accomplish Agreement goals); and training evaluation practices.
3. Oversight and Monitoring – identification of measures and operational objectives; selection and validation of performance measures, benchmarks, and targets for improvement over time; use of measurement and analysis to identify relative areas of success and weakness; measurement of stakeholder and family engagement (e.g., survey instruments, focus groups, independent observation, etc.); case reviews with attached methodology (e.g., random sampling, statistical sampling, etc.); performance improvement plans; audits and auditing procedures.
4. Data-driven Quality Improvement – planning, implementation, and regular use of well documented, structured, iterative processes for reviewing data from #3, above, to drive continuous quality improvement; goal setting, looking at the actual data for performance measures, and acting on results.